CEDAR FALLS COMMUNITY SCHOOLS—PHYSICAL EXAM

Name____DOB_______________Grade________Gender M F
Last First M I (circle one)
Address____Phone_________________Date ____________________

X = normal - -describe impairment

History of serious illness:____
Injuries and Surgery ____
Allergies: ____
Eye_______________Ears________________Nose________________Throat_____________Lungs_______________Heart ______________
Abdomen_________________________Hernia_____________________Genitalia_____________________Neuroloical__________________
Orthopedic____ Scoliosis: Yes_______________No_________Urinalysis ______________
HGB__________Blood Pressure _______Height______Weight_____ Heart Rate: Before Exercise_____After Exercise ___________________
General Physical Condition: Excellent____Good____Fair____Below Average____
Did you recommend a referral (ENT, Eye, Orthopedic, etc.)? Yes____________ No__________
If yes, what kind____
Physician's recommendation ____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
DPT/DT					
POLIO					
MMR					
HAEMOPHILUS B					
HEPATITIS B					
VARICELLA					
Other (please list)					

PHYSICIAN'S REPORT

I hereby certify that_______________________was examined by me and found physically fit to engage in all physical education classes, extramurals, and school athletics. RESTRICTIONS____Duration ___________________________
If restrictions, why?___________________________What activities may he or she not enter? ____
Physician's Signature____Office Phone _________________________

Form HD 20A-0 rev.07-10