East Buchanan Community Schools
414 5th St. N Winthrop, IA 50682
Phone- (319) 935-3660 Fax- (319) 935-3749

*****PARENTS- PLEASE FILL OUT THIS SIDE*****

Student _____

Female Male Date of Birth _____

MEDICAL AND HEALTH HISTORY

HISTORY	DATE	COMMENTS	
Prenatal/Birth			
Lead Screening (Required)		Results:	
Asthma			
Medications			
Illness, serious			
Chickenpox		□ Diagnosed	□ By Report
Injury, serious			
Hospitalization, Surgery			
Immunizations **(Attach IRIS Form)**	□ Up to date for school entry □ Boosters needed:		
Other			

Parent's Statement on Sharing of Information:
Information on this form is confidential and will be filed in my student's classroom. I acknowledge that the information noted on this form will be shared with school staff members only on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature: _____

Date: _____

**** THIS SIDE IS TO BE FILLED OUT BY FAMILY PHYSICIAN****
**** PLEASE ATTACH IMMUNIZATION FORM TO THIS PHYSICAL FORM**

PHYSCIAL EXAM AND ASSESSMENT
By Physician, Nurse Practitioner, or Physician Assistant

Date of Exam: _____

Height _____ Weight _____ Blood Pressure _____

Vision: Both 20/_____ Right: 20/_____ Left: 20/_____

SYSTEM	WNL	Comments:
Skin		
Eyes		Referred:
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Spinal		Scoliosis Screening: WNL_____Referred____
Neurologic		
Emotional/Social		
Allergies- Please list in Comments section		Epi-Pen: □ Yes □ No
Labs if indicated		
TB Risk		Mantoux if indicated
Health conditions requiring intervention/modification at school:		

Physical Education Program: Full_____ Limited_____ None_____
Reason:

Examined by (print) _____

Signature: _____ Date: _____

Clinic: _____ _____ Phone: _____