



2301 East Court Street
Lower Level
Iowa City, IA 52245
338-3949

PHYSICAL ASSESSMENT & HEALTH FORM

1. HEALTH STATEMENT: To be completed by parent.

Child's full name

Birth date

1. Significant illnesses and surgeries child has had (give age at time):

2. Any special health-related needs of child (**allergies**, medications, injuries, etc.):

2. PHYSICAL ASSESSMENT: To be completed by a physician or his/her designee.

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action? _____

2. Is this child subject to conditions which limit classroom activities or physical education?

3. Is this child subject to any condition which may result in an emergency situation?

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation? _____

5. Are immunizations up to date: ____ Yes ____ No ____ If no, what is needed?

6. Other significant findings: _____

He/She **IS** **IS NOT** (circle) physically and emotionally able to participate in the Program.

Recommendations: _____

Date of examination _____ Doctor's signature _____