JOHNSTON™
COMMUNITY SCHOOL DISTRICT

5608 Merle Hay Road • P.O. Box 10 • Johnston, IA 50131 • (515) 278-0470 • www.johnstoncsd.org
Superintendent: Dr. Corey Lunn

Dear Parent:

Johnston School Health Services encourages regular health examinations of all children by their family physician. The schools request examinations and medical reports annually of all preschool, kindergarten, 3rd, 6th grade students, all students who are new to the district, and those with known health problems in any grade.

Those students who will be participating in sport programs may request an athletic physical form from either the health office or athletic office.

After your doctor makes the examination, please return the medical report on the reverse side to the school your child will be attending.

A medical report is very helpful in planning the best health program for your child. If your child has a specific health need or you need assistance with locating medical care, please notify the school nurse at your child's school building.

Sincerely,
Johnston School Nurses

Johnston Community School District
Physical Examination

to be completed by physician

Student's Name	Birthdate	Male/Female
Parent's Name	Phone	
Physician's Name	Phone	

	Date	Comments		Date	Comments
Allergy to Food			Diabetes		
Allergy to Medicine			Freq. Ear Infections		
Other Allergies			Meningitis		
Asthma			Mono		
Bleeding Problems			Seizures		
Cancer			Surgery		
Cardiac Concerns			Freq. Throat Infections		
Chicken Pox			TB		
Concussion			Other		

Height	Weight	BP	Hemoglobin	Lead Screen	Vision (right)	Vision (left)	Lenses?	Hearing

	Normal (√)	Abnormal (√)	Comments (required for abnormal)
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose			
Mouth/Dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Endocrine			
Spinal Examination			
Nutritional Status			
General Appearance			
Developmental			
Other			

Medications _____

Conditions that might affect school performance _____

Full and Unlimited Athletic Participation Yes No

If no, list activity restrictions _____

Physician's Signature _____ Date_____