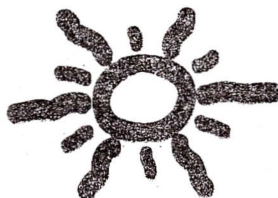

Pediatric Center P.C.

"Our focus is your child"

411 10th Street, SE Cedar Rapids, Iowa 52403 319-363-3600

CHILD'S NAME______________________________ AGE____________

Height____________________ Weight____________________

Eyes ____________________ Lymph Nodes____________________

Teeth____________________ Throat____________________

Heart________________ B.P.__________ Femoral Pulse__________

Spine and Back________________________ Gait________________

Urinalysis (if needed)________________________ Hemoglobin__________

Vision- R Eye______________ L Eye__________ Both__________

Hearing- Normal______________ Abnormal____________ Not tested______

Tuberculin Screening (if needed) ______________________________

Developmental Screening (if needed)______________________________

Allergies____

Medications ____

Restrictive Conditions:____________________________________

Summary of Findings and Recommendations:
____________________(Name)________(is)______(is not) physical and

emotionally able to participate in your program.

Additional Comments:______________________________________
____

IMMUNIZATIONS: Are______Are Not______complete for age.

____

Signature of Physician Date of Examination

Julianne H. Thomas MD, FAAP | Sharon A. Collins MD, FAAP | Sarah K. Wickenkamp MD, FAAP | Trudy B. Goldman MD, PhD, FAAP | Linda M. McDermott MD, FAAP | Marie E. Svatek MD, FAAP | Jorie J. Shire MD