



Student Physical Form

Noah's Ark Preschool | 6455 E Ave. NW | Cedar Rapids, Iowa 52405
Ph. 319-396-3125 | office@noahsarkcr.org | Fax 319-390-4728

Child's Full Name: _____

Sex _____ Date of Birth ____/____/____

Street Address _____ City _____ Zip code _____

Mother's name _____ Father's name _____

Home Phone _____ Cell Phone _____ Cell Phone _____

Family Doctor Name _____

Address _____

Phone _____ Fax _____

Medical Examination Record

Height _____ Weight _____

Allergies (indicate Type) _____

Prescription for Allergy? yes / no If yes, what? _____
(circle one)

Eyes _____ Vision _____ Ears _____

Hearing _____ Nose _____ Throat _____

Mouth _____ Urinalysis _____ Chest _____

Heart _____ Pulse Rate _____ Hernia _____

Extremities _____ Diabetes _____ Asthma _____

Past surgeries _____

Immunizations up to date? _____ Please send a signed/official copy of record along with this form.

Are there any health conditions the school must be aware of?

Restrictions and/or Recommendations:

Physician's Signature: _____

Date of Exam: _____