HEALTH FORM 602 (7/27/07)

MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT

STUDENT PHYSICAL EXAMINATION

Student Name ______________________ Date of Birth__________ School______________

Parent's Name______________________ Phone Number______________________

This physical examination is required to be performed by a physician (M.D., or D.O.), advanced nurse practitioner (A.N.P.), physician's assistant (P.A.) or a chiropractor (D.C. , within scope of chiropractic practice).

Note: This form is not to be used for athletic physical examinations.

PHYSICAL EXAMINATION

Height__________ Weight__________ B/P__________ Vision: Both__________ Right__________ Left __________

Cover______ Color Acuity________ Hearing: Right________ Left_______ Audiometer used_______ /or Other_________

Exam Finding:
○ = No abnormality √ = Abnormality- specify under comments section

Eyes______________________
Nose/Throat______________________
Lymph Nodes______________________
Heart______________________
Abdomen______________________
Orthopedic______________________
Skin______________________
Nutrition______________________

Ears______________________
Mouth______________________
Teeth______________________
Lungs______________________
Genitals______________________
Nervous System______________________
Endocrine______________________
Other______________________

Comments/Follow-up Needed: ____

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IMMUNIZATION RECORD or attach copy

Note: Month, day and year must be present to be considered valid

DTP/DTaP					
Td/Tdap					
Polio					
MMR					
Hep A					
Hep B					
Varicella					
Hib					
PPD					
Other:					

____________________ ______________________________________

Date Signature of Physician M.D. or D.O.,/A.N.P.,/P.A.,/D.C.

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Phone Number Printed Name of Physician M.D. or D.O.,/A.N.P.,/P.A.,/D.C.