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_____ Ears_____
Nose/Throat_____ Mouth_____
Lymph Nodes_____ Teeth_____
Heart_____ Lungs_____
Abdomen_____ Genitals_____
Orthopedic_____ Nervous System_____
Skin_____ Endocrine_____
Nutrition_____ Other_____

Comments/Follow-up Needed: _____
_____
_____

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.

_____ _____

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