

HEALTH FORM 602 (5/2014)

MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT

STUDENT SCHOOL ENTRY 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:

o = 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

Table with 6 columns and 11 rows for immunization records including DTP/DTaP, Td/Tdap, Polio, MMR, Hep A, Hep B, Varicella, Hib, PPD, and 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.