BROKEN BOW PUBLIC SCHOOLS PHYSICAL EVALUATION FORM

Student's Name:____
(Last) (First) (Middle Initial)

Parent/Guardian's Name:______________________________________

Address:____

Telephone Number:____
(Home) (Work)

Grade:______________Age:_______________Date of Birth:_______________Place of Birth: ____________________

Family Physician:_______________________________Clinic Address:____

SIGNIFICANT PAST MEDICAL HISTORY:
____
____

DAILY OR REGULAR MEDICATIONS:________________________________
____

IMMUNIZATIONS:

DTP, DT, DTaP: ____
OPV, IVP: ____
HIB: ____
MMR: ____
HEP B: ____
VARICELLA/CHICKEN POX: ______________________________________

Height: ____________ Weight: ____________ Blood Pressure: ____________

	NORMAL	ABNORMAL FINDING	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Signature of physician/nurse practitioner/physician assistant ________________________________

I give permission for this form and the information provided within to be shared with the Broken Bow Public Schools.

Parent Signature: ____________________________________ Date: ______________________