Committed to Equity & Excellence

Hopkins Public Schools
1001 Highway 7
Hopkins, MN 55305-4723
952.988.4000
www.hopkins.k12.mn.us

HOPKINS PUBLIC SCHOOLS

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PHYSICAL EXAMINATION

NAME_____M_____F_____
(Last) (First) (Middle)
Date of Birth_____Grade_____School_____

Parent/Guardian_____

Address_____Phone_____

PHYSICIAN'S FINDINGS AND RECOMMENDATIONS

Height_____Weight_____
Eyes: Right 20/_____ Left: 20/_____
Glasses Worn: Yes_____ No_____
Ears: Right_____ Left: _____
Nose_____
Throat_____
Glands_____
Heart_____
Lungs_____

Blood Pressure_____
Orthopedic_____
Scoliosis Screening _____
Nervous System_____
Skin_____
Posture_____
Nutrition_____
Hemoglobin_____
Urinalysis_____

Allergies _____
Chickenpox: Date of Disease_____/ Date of Immunization _____
Medical Diagnosis _____
Current Medication/ Dosage _____

Kindergarten Dev. Screening Completed by Physician Yes_____ No_____
Tool Used_____ Pass_____ Fail_____ Date of Screening_____
Comments_____
_____
_____

Is there any reason why the above student should not participate in inter-scholastic athletics? Yes_____ No _____ If yes, please specify _____

Physician's Name: _____ Date_____
Physician's Signature_____
Telephone_____
Clinic Name/Address_____
Physical Exam Date: _____

Please Return This Form to Your School Nurse

(Complete the Immunization Record Form on Reverse Side or attach record from clinic)