

Our Savior Lutheran School  
Preschool 2s – Grade 8  
1500 San Simeon Way, Fenton, Missouri 63026  
[www.oursaviorles.org](http://www.oursaviorles.org) 636-343-7511

**Health Information and Physical Exam Form for:**  
**NEW students entering Early Childhood to 8th grade & ALL Kindergarten, 4th, and 7th grade students.**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**Health History - to be completed by parent/guardian**

History/Medical Diagnoses – Check any that apply:

Asthma     ADHD     Chicken Pox     Diabetes     Epilepsy     Heart/Lung

Hearing     Glasses/Contacts     Surgery: \_\_\_\_\_

Allergies - Medication: \_\_\_\_\_  Allergies - Food: \_\_\_\_\_

Other Health Concerns: \_\_\_\_\_

*Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, will need additional health care plans. Please contact the school nurse to complete this information.*

Orthopedic History – Check any that apply:

Head Injury     Leg/foot Injury     Back/Neck Injury    Explain: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dentist's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and address in case of an emergency. The school nurse may contact the health care provider regarding any health concerns pertaining to students. I understand that basic first aid and emergency care will be provided as needed by school staff. I understand an update immunization record must be on file with the school prior to first day attendance.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physical Examination – to be completed by Physician**

Date of Exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_ / \_\_\_\_\_

Pulse: \_\_\_\_\_ Eyes: R: \_\_\_\_\_ L: \_\_\_\_\_ Hearing: \_\_\_\_\_

History/Medical Diagnoses – Check any that apply: **IMMUNIZATION RECORD must be attached**

Chronic Condition/Major Surgeries: \_\_\_\_\_

Allergies (list): \_\_\_\_\_  Medications (list): \_\_\_\_\_

Special Seating Recommendation: \_\_\_\_\_  Scoliosis: \_\_\_\_\_

Medications to be taken at school (list): \_\_\_\_\_

ORTHOPEDIC EXAM (for PE/sports participation)

ROM Back Neck Shoulders Lower Extremities Upper Extremities

If not, explain: \_\_\_\_\_

Full Participation     Limited(explain): \_\_\_\_\_  None

Physician's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_