1500 San Simeon Way, Fenton, Missouri 63026
www.oursaviorlcs.org Phone: 636-343-7511 Fax: 636-343-4921

Health Information and Physical Exam Form for:
NEW students & 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:**_________________________