HISTORY OF ILLNESS (completed by the Parent)

	DATE AND COMMENTS
ALLERGY AND ASTHMA	
CONVULSIVE DISORDERS	
CHEST CONDITIONS	
CHICKENPOX	
DIABETES	
EYE, EAR, NOSE DISORDERS	
HEART CONDITION	
MEASLES	
GERMAN MEASLES	
GLASSES/CONTACTS	
MUMPS	
RHEUMATIC FEVER	
STREP INFECTION/SCARLET FEVER	
TONSILLITIS	
WHOOPING COUGH	
OPERATIONS	
SERIOUS INJURY/ACCIDENT	
OTHER:	

IMMUNIZATIONS (Give all dates: Month/Day/Year)

DPT/DTaP						
Td						
Tetanus						
Polio - Oral						
Polio - Inj						
MMR						
Hep B						
Varicella/Varivax						
HiB						
Hep A						
Other						

PHYSICAL (completed by the Doctor)

Height:_____**Weight:**_____

General Physical Development:_____

Posture:_____

Eyes: Pupils _____

Conjunctivitis: _____

Strabismus: _____

Ears: Drums:_____

Canals: _____

Nose:_____

Mouth: Tonsils: _____

Tongue: _____

Throat: _____

Gums: _____

Lymph Nodes: _____

Thyroid:_____

Lungs: _____

Thorax: _____

Heart: _____

Pulse and rhythm: _____

Blood Pressure: _____

Abdomen: _____

Hernia: _____

Genitalia: _____

Feet: _____

Skin: _____

Nervous System: _____

Nutrition: _____

Laboratory Reports:_____

Other:_____

_____

RECOMMENDATIONS: (By Physician)
Can pupil carry a full program at school?
Yes_____ No_____

Is special seating recommended?
Yes_____ No_____

If "yes" specify -_____

_____

Other recommendations and remarks:_____

_____

_____

This person has been examined by me and may engage in all normal school activities, including athletics, unless otherwise noted.

_____
Physician's signature Date

_____
Physician's address Phone

- -

Complete & Sign if your child will be participating in Interscholastic Sports

I hereby give my consent for _____
Student's Name
to participate in the Interscholastic Athletic Program at Salem Lutheran School, 5190 Parker Rd., Florissant, MO 63033, Grade level _____. We will be responsible for transportation for practices and games. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary in the course of such athletic activities or such travel. I agree also not to hold the school or anyone acting in their behalf responsible for any injury occurring to my child.

_____
_____
Parent or Guardian's Signature

Revised 1/28/25

PHYSICAL FORM - 2025-2026 *Exam date after 03/01/25*

SALEM LUTHERAN SCHOOL
5190 PARKER ROAD, FLORISSANT, MO 63033
(314)741-8220

This form is **due no later than FRIDAY, AUGUST 1** for:
(1) new students (see * below)
(2) students entering Kindergarten
(3) 3rd grade students
(4) 7th grade students
and prior to the first practice for:
(5) athletic participants

Name of Student:_____

Address:_____

_____Phone:_____

Grade:_____ Birthdate:_____Sex:_____

Physician to be called in case of an emergency:

_____

(Name) (Address) (Phone)

The policy of Salem Lutheran School is that everyone attending Salem Lutheran School must have a physical examination report on file in the student's Cumulative Health Record folder before the beginning of the new school year. An exam dated after 3/1/25 is required of all students entering PK and/or K, and grades 3 & 7. (*If a student transfers to Salem, a previous physical exam will be honored provided that the child has had it on the recommended schedule.) It is the belief that this type of program will enable the home and school to cooperate more effectively in preventing defects or caring for them after they have developed. So much of your child's success and happiness in school and in life is dependent upon his/her physical and mental health that we are confident that this program is vital in providing the best school life for your child. We appreciate your cooperation in this matter.

Mr. Jeff Burkee, Principal