Dear Parents:

In accordance with the recommendations of the Missouri Department of Health Committee, all children are expected to have a complete physical examination upon entrance into our school and at the beginning of Kindergarten and at the beginning of the year if they are participating in sports. Evidence that the child has had this physical examination should be furnished to the school.

After completion of this examination form, please return it to the school office. Thank you for your cooperation.

Mrs. Allison Dolak
Principal of Immanuel Lutheran School

HISTORY OF ILLNESS (Dates):

Chicken Pox ____________	Measles ____________
German Measles ________	Asthma ____________
Rheumatic Fever ________	Convulsions _________
Strep Throat ____________	Hepatitis ____________
Ear Infection ____________	Other ______________

Medications: ______________________________________

____

____

Please tell of any other illness, allergies, injuries, or operations:

Form F-1
Rev. 6/17/10

Immanuel Lutheran School
632 E. Hwy N
Wentzville, MO 63385

Student's Name _________________________ Grade _____

Address ______________________________________

Phone ____________ Birthdate ____________ Sex ______

Father or
Guardian ______________________________________
Name Employer

____
Employer's Address Phone

Mother or
Guardian ______________________________________
Name Employer

____
Employer's Address Phone

Emergency ______________________________________
Name Address Phone

Family Physician ______________________________________
Name Address Phone

Family Dentist ______________________________________
Name Address Phone

Family
Eye Doctor ______________________________________
Name Address Phone

IMMUNIZATIONS (Dates): We need the month, day and year of each immunization and test.

D.P.T./DTAP Series: (1) _________ (2) _________

3) _________(4) _________ (5) _________ (6) _________

DT: (1)____________

TDap: __________________________

Inactive Polio Vaccine: (1) ___________ (2) ___________
(IPV)

(3) ___________ (4) ___________ (5) ___________

MMR (Measles, Mumps, Rubella): (1) _______ (2) _______

HIB: _________ _________ _________ _________

Hepatitis A Series (1) ________ (2) ________

Hepatitis B Series: (1) ________ (2) ________ (3) ________

Varicella: (1)________________Booster ________________

Pneumococcal (PCV)_________________________

Other______________________________________

____

PHYSICAL EXAMINATION BY A PHYSICIAN:

Height _________ Weight _________

Nose ___________ Lungs ___________Heart ___________

Skin ____________ Mouth ___________ Tongue _________

Eyes ___________ Abdomen __________ Hernia ________

Ears ___________ Thyroid __________ Thorax __________

Blood Pressure: ______________

Nervous System: ______________

Lymph Nodes: _______________

Posture ________ Scoliosis ________ Genitalia ________

Speech Defect _________ Lab. Rep. ________________

Throat/Tonsils: Enlarged ___ Diseased ___ Removed ____

Chronic Illness: ____________________________________

____

Teeth need attention: Yes _____ No _____

Vision with/without glasses: R _______ L ______

Hearing: R _______ L _______

Is special seating recommended: Yes _____ No _____

Should physical activity be restricted? Yes _____ No _____

Recommendations:

Physician __________________________Date _________