Polk County PUBLIC HEALTH
WE PUT HEALTHY IDEAS TO WORK

Cathedral School Phone: (218) 281-1835 Fax: (218) 281-1747

Cathedral School Health Information Sheet: Parent's Report

Student's Name: _____ _____ Birthdate: ____/____/____ Grade: _____
Parent's Name: _____
Phone (H): _____ (W): _____ (C): _____
Address: _____ City: _____ Zip: _____
Physician: _____ Clinic: _____ Phone: _____
Dentist: _____ Address: _____ Phone: _____
EMERGENCY CONTACT (if parent is unavailable): Name: _____
Phone: _____ Address: _____ City: _____ Zip: _____

YES	NO	PROBLEM	IF YES, EXPLAIN
		Vision Problem: Glasses or Contacts	
		Hearing Problems	
		Allergies: To What? Type of Reaction?	
		Stomach Problems	
		Heart Problems (Ex: Murmur)	
		Skin Problems	
		Bladder or Kidney Problems	
		Bone, Joint, or Muscle Problems	
		Diabetes	
		Lung Problems (Ex: Asthma)	
		Epilepsy or Seizures	
		Surgeries or Hospitalizations	
		Mental Illness (Ex: Depression, Anxiety, etc.)	
		Emotional Problems	
		Behavior Concerns (Ex: concerns, ADD, ADHD, etc.)	
		OTHER: Chickenpox History	Date of Chickenpox Illness: _____

*The items in RED will need additional paperwork completed each school year. The School Nurse will send you the forms.

Does your child take any medication? ____Yes ____No

If medications are to be given in school, please contact the Cathedral School for the **Medication Consent Form.** The form is **REQUIRED** for all medications taken at school including prescription and over the counter meds and must be signed by BOTH the medical provider and the parent.

I agree to allow the above information to be shared with teachers and staff in order to provide comprehensive care to my student.

Parent or Guardian's Signature: _____ **Date:** _____

Thank you for completing and returning these forms. Please let me know if you have questions or concerns regarding your child's health!

Jill Perkerewicz, Registered Nurse Polk County Public Health

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