Our Savior's Lutheran School | Phone: (218) 281-5191
Our Savior's Lutheran School Health
Information Sheet: Parent's Report

Polk County PUBLIC HEALTH
WE PUT HEALTHY IDEAS TO WORK

Student's Name: _____ Birthdate: ____/____/____ Grade: _____
Parent's Name: _____ Phone: _____
Address: _____ City: _____ Zip: _____
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.)	

Does your child take any medication? ☐ **Yes** ☐ **No**

If medications are to be given in school, please contact the Our Savior's Lutheran School for the **Medication Consent Form.** The form is **REQUIRED** for all medications taken at school including prescription and over the counter meds (including Tylenol, Ibuprofen, Benadryl) and must be signed by BOTH the medical provider and the parent.

Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system.

Giving permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota Law, all information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

☐ I have provided my child's immunization records to Our Savior's Lutheran School
☐ I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system
☐ I agree to allow the above information to be shared with teachers and staff to provide comprehensive care to my child.

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

Please turn over

Has your child had their first dentist appointment? ☐ Yes ☐ No
If yes, when? _____
Does your child have a regular health care provider? ☐ Yes ☐ No
If yes, whom and which clinic? _____
Does your child have health insurance? ☐ Yes ☐ No
If not, we can help you sign up for coverage, please ask.

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

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