ST. FRANCIS CATHOLIC SCHOOL STUDENT INFORMATION FORM

SCHOOL YEAR 2022-2023

Student's LEGAL Name: _____

Grade: _____ **Gender:** ____ **Birthdate:** _____ **Birthplace:** _____ **Religion:**_____

Parent Contact Info: _____**Mom** _____**Dad**

Name: _____

Address: _____

City, ST Zip: _____

Primary Contact#: _____ Type: _____

Secondary Contact#: _____ Type: _____

Other#: _____ Type: _____

Email:_____

Parent Contact Info: _____**Mom** _____**Dad**

Name: _____

Address: _____

City, ST Zip: _____

Primary Contact#: _____ Type: _____

Secondary Contact#: _____ Type: _____

Other#: _____ Type: _____

Email:_____

(Please * any changes in contact information from last year)

Student lives with: ____**Father** ____**Mother** ____**Both** **Other**_____

Would you like information to be shared with both parents/guardians? _____**Yes** _____**No** _____**N/A**

Emergency Contact: Relationship _____

Name: _____

Primary Contact#: _____ Type: _____

Secondary Contact#: _____ Type: _____

Other#: _____ Type: _____

Emergency Contact: Relationship _____

Name: _____

Primary Contact#: _____ Type: _____

Secondary Contact#: _____ Type: _____

Other#: _____ Type: _____

Family doctor: _____

Work Phone: _____

Family Dentist: _____

Work Phone: _____

Medical Concerns or Medications: (i.e.: asthma, seizures, diabetes, allergies) (Please list below, or use the back of the sheet.)

_____

_____

I consent:

Field Trips: (Any field trips taken during the school year) _____ *Yes* _____ *No*

Photos/Media (for publications, Facebook,etc) _____ *Yes* _____ *No*

Student Directory _____ *Yes* _____ *No*

Internet _____ *Yes* _____ *No*

Is there a custody or restraining order in effect? _____ *Yes* _____ *No*

OTC: *Yes* *No* - For school authorized personnel to administer to my child as needed (Acetaminophen, Cough drops, Antibiotic ointment, Benedryl/Caladryl Cream, *Oral Benedryl are available)

Face Mask: _____ I understand that if my child goes to the Nurse's office with COVID-19 symptoms that they will be required to wear a mask until they are picked up from the building

The following people are allowed to pick up my child/ren_____

I agree, that the information on this sheet to be current for the school year and that if my (our) child becomes ill or is injured at the school and needs to be taken home and I (we) cannot be reached, the above listed people have been informed of their responsibility and have my (our) permission to receive information about and provide transportation and care for my (our) child.

Parent/Guardian Signature: _____ **Date:** _____

FIRST DAY OF SCHOOL

Please complete and return this form so the teacher has it the first day of school.

After school on the first day:

My child _____

Will walk _____ address _____

Will ride bus _____ address _____

bus number _____ bus driver _____

Will be picked up by _____

****

Every day thereafter, unless my child brings a note:

My child _____

Will walk _____ address _____

Will ride bus _____ address _____

bus number _____ bus driver _____

Will be picked up by _____

Remarks _____
Example: Church Day, Dance Day, etc.

****

If school is dismissed early because of bad weather, we would like your cooperation to know where to send your child.

My child _____

Will walk _____ address _____

Will ride bus _____ address _____

bus number _____ bus driver _____

Will go home with _____

Will be picked up by _____

Thanks so much for your cooperation. This will be so helpful for us in the future.

PARENTS **COMPLETE THIS PAGE Child's Name: _____**

Parents: Tell us about your child's health. Place an **X** in the box if the sentence ap plies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth
I am concerned about my child's growth.

Appetite
I am concerned about my child's eating / feeding habits or appetite.

Rest -
I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child had a serious illness, injury, or surgery.
Please describe.

Physical Activity - My child must restrict physical activity.
Please describe.

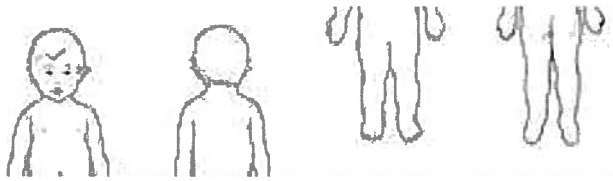
Development and Learning
I am concerned about my child's behavior, development, or learning.
Please describe:

Medication - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

Body Health - My child has problems with

Skin, birthmarks, Mongolian spots, hair, fin gernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



Eyes \ vision, glasses Ears \ hearing, hearing aides or device, ear- aches, tubes in ears
Nose problems, nosebleeds, runny nose
Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
Frequent sore throats or tonsillitis
Breathing problems, asthma, cough, croup
Heart, heart murmur
Stomach aches, upset stomach, colic, spitting up
Using toilet, toilet training, urinating
Bones, muscles, movement, pain with mov ing
Mobility, uses assistive equipment
Nervous system, headaches, seizures, or nervous habits (like twitches)
Needs special equipment. *Please describe*:

Allergies-My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: _____

Birthdate: Age today: Date of Exam:_____

Height/Length:

Weight:

Head Circumference-for children age 2 yr and under: Blood Pressure-start @ age 3 yr:

Hgb or Hct-anytime between 6-9 mo:

Blood Lead Level-start @ 12 mo:

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening[2]**:**

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐No

Exam Results: *(n = normal limits) otherwise describe* HEENT

Oral/Teeth

Oral Health/Dental Referral Made Today: Yes No Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health con dition signed by an approved health care provider. The American Acad emy of Pediatrics has recommendations for frequency of childhood pre ventative pediatric health care (RE9939, March 2000) www.aap.org [2] Developmental screening procedures were expanded to include aut ism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383- 3826.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td MMR

Hepatitis B Pneumococcal

HIB Varicella

Polio Other

Influenza

TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or pre school: (include *over-the-counter* and *prescribed*)

Medication Name Dosage Cough medication
Diaper crème:
Fever or Pain reliever:
Sunscreen:
Other

Other Medication should be listed with written instructions for use in child care.

Referrals made:

Referred to ***hawk-i*** today 1-800-257-8563
Other: _____

Health Provider Assessment Statement:

The child may participate in developmentally ap propriate child care/preschool with ***NO*** health-related restrictions.

The child may participate in developmentally ap propriate child care/preschool ***with the following re strictions***:

May use stamp

Signature _____ **Circle the Provider Credential Type: MD DO PA ARNP** Address: Telephone: