KIDDIE ACADEMY®
EDUCATIONAL CHILD CARE

CHILD HEALTH RECORD

Child's Name:_____ Birth Date:_____
Last First Middle

Name of Parent/Guardian:_____ Relationship:_____

Home Address:_____
Street City State Zip

Home Telephone:_____

Dear Parent/Guardian:

All children should have regular health check ups, immunizations and physical exams from birth to 18 years of age.

State law requires you to submit proof of age-appropriate immunizations on the attached Immunization Certificate to Kiddie Academy prior to the child's first day.

This form is partially completed by you and the other portion will be completed by your physician. Please complete prior to your child's first day at the Academy.

PLEASE RETURN THIS COMPLETED FORM TO:

Kiddie Academy of:_____

Academy Address:_____
Street

_____
City State Zip Code

Academy Fax Number:_____

HEALTH HISTORY:

Section A: To be completed by parent/guardian	YES	NO
1. Are you concerned about your child's general health (eating, sleeping habits, posture, teeth, skin, weight, bowel/bladder, etc.)? If Yes, please explain:_____	❑	❑
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes)? If Yes, please explain:_____	❑	❑
Date of last eye examination: _____/_____/_____ Doctor's Name:_____		
Results:_____		
Does your child wear glasses or contact lenses? _____	❑	❑
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, etc.)? If Yes, please explain:_____	❑	❑
Date of last hearing evaluation: _____/_____/_____ Doctor's Name:_____		
Results:_____		
Does your child use a hearing aid?_____	❑	❑
4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)? If Yes, please explain:_____	❑	❑
5. Does your child have any allergies (food or medical)? If Yes, please list:_____	❑	❑
6. Does your child have any other specific illness, disability or other limiting condition(s)?	❑	❑
(a) Does this condition require any special health care in the child care facility or school? If Yes, please explain:_____	❑	❑
(b) Has your child been evaluated in such a way that it could help the child care provider or teacher meet his/her health or education needs? If Yes, please explain:_____	❑	❑
7. Do you have any concerns about your child's behavior or emotional well-being which the child care provider or school should know about? If Yes, what are your concerns?_____	❑	❑
8. Has your child had any of the following? _____Chicken Pox _____Whooping Cough _____ Other:_____	❑	❑
9. Has he/she ever had any serious illnesses or hospitalization? If Yes, please explain:_____	❑	❑
10. Does your child have any physical disabilities? If Yes, please explain:_____	❑	❑

What arrangements can you make for care during illness?_____

How many colds has your child had this past year?_____

How does your child react to an elevated temperature?_____

Please give us any special instructions if the child becomes ill?_____

Is your child on any medications, regularly? If yes, please list medication and reason(s):_____

PARENT'S STATEMENT - PLEASE SIGN AND DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE SECTION B OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS AT KIDDIE ACADEMY.

_____ _____
Parent's Signature Date

ONLY COMPLETE FOR SCHOOL AGE CHILD:

I give my permission to_____School to release_____'s
Name of School Name of Child
health information to Kiddie Academy® of_____.

_____ _____
Parent's Signature Date

Section B: To be completed by a HEALTH PRACTITIONER

Child's Name:_____ Child's Date of Birth:_____

1. Date of this child's most recent tuberculin test:_____/_____/_____. Result: _____Positive_____Negative.
2. Date of this child's last tetanus shot: _____/_____/_____
3. This child has the following which may significantly affect his/her child care or educational experience:

		COMMENTS
a. Vision problem	□ YES □ NO	
b. Hearing problem	□ YES □ NO	
c. Speech or language problem	□ YES □ NO	
d. Other physical illness or impairment	□ YES □ NO	
e. Mental, emotional or behavior problems	□ YES □ NO	
f. Developmental delays	□ YES □ NO	
g. Allergies	□ YES □ NO	

Significant physical findings, comments and recommendations:_____

4. This child has a health condition which may require care or emergency action while at child care/school. _____YES ___ NO
   Please specify (e.g., seizures, bee sting allergy, diabetes, etc.):_____
   Recommendations:_____
5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school. ___YES ___NO If YES, please specify:_____
6. This child requires a modified diet and/or special feeding procedures. ___YES ___NO
   If YES, please specify:_____
7. Does this child have any limitations that would effect full participation at the academy? ___YES ___NO
   If YES, please specify:_____
8. Does the child's physical activity need to be restricted? ___YES ___NO
   If YES, please specify:_____
9. Does this child require any specialized treatment? ___YES ___NO
   If YES, please specify:_____
10. Does this child require any adaptive equipment (e.g., braces, crutches, etc.)? ___YES ___NO
    If YES, please specify what type:_____
    Special instructions for use:_____
11. Additional comments:_____

HEALTH ADDENDUM

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name:_____

Medical Condition(s):_____

_____

Medications currently being taken by your child:_____

Allergies/Reactions:_____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/Symptoms to look for:_____

_____

(2) If signs/symptoms appear, do this:_____

_____

(3) To prevent incidents:_____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:_____

_____

COMMENTS:_____

_____

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I CONDUCTED A PHYSICAL EXAMINATION OF THE ABOVE-NAMED CHILD ON _____ (date) AND FIND THAT HE/SHE *IS / IS NOT* MEDICALLY CLEARED TO ATTEND KIDDIE ACADEMY.
(Circle One)

_____ (_____)_____
Name of Health Practitioner (Signature) Telephone Number