KINDERGARTEN HEALTH HISTORY FORM

KEOTA COMMUNITY SCHOOL DISTRICT-KEOTA ELEMENTARY 2014-2015

Child's Name: _____ Birthdate: _____/_____/_____ M / F

Parent(s)/Guardian(s):_____ Phone: _____

Child's Physician/Clinic:_____ Phone: _____

Dentist/Clinic: _____ Phone: _____

Hospital Preference:_____

Does your child have any of the following, or does he/she have a history of any of the following?

	YES	NO	
1.	___	___	Asthma
2.	___	___	Seizures
3.	___	___	Diabetes
4.	___	___	Heart Problems
5.	___	___	Depression/Anxiety/Emotional Problems
6.	___	___	Bladder/Urinary Tract Problems
7.	___	___	Stomach/Bowel Problems
8.	___	___	ADD/ADHD
9.	___	___	Food allergies
10.	___	___	Drug/medication allergies
11.	___	___	Dust/pollen/other allergies
12.	___	___	Require use of an EpiPen for any allergies
13.	___	___	Vision problems Wears glasses___ Wears contact lenses___
14.	___	___	Hearing problems Left ear___ Right ear___ Hearing aid(s)___
15.	___	___	Eating problems/dietary concerns
16.	___	___	Headaches
17.	___	___	Take Medications on a daily basis, if so please list: _____
18.	___	___	Chicken Pox
19.	___	___	Other_____

Describe health condition(s) to which you answered "yes" above:

_____

_____

_____

Does your child have any vision, hearing or speech concerns that the school should be aware of and/or make accommodations for? YES___NO___ Describe_____

_____

Does your child have any condition that may affect their participation in classroom activities?
YES___NO___

Does your child have any condition that may affect their participation in physical education/physical activities?
YES___NO___

Parent Signature: _____ **Date:** _____

IT IS THE PARENT'S RESPONSIBILTY TO PROVIDE A COMPLETED IMMUNIZATION CERTIFICATE FOR EACH CHILD PRIOR TO ENTRY INTO SCHOOL!