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:

It is pertinent that all children have regular health check ups, immunizations and physical exams from birth to 18.

State law requires you to submit proof of age-appropriate immunizations on the attached Immunization Certificate to the Kiddie Academy center 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.

PLEASE RETURN THIS COMPLETED FORM TO:

Kiddie Academy of Greenlawn

787 Pulaski Road

Greenlawn, NY 11740

Fax #: (631) 261-0111

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? □ □

If Yes, please explain:____

6. Does your child have any other specific illness, disability or other limiting condition? □ □

(a) Does this condition require any special health care in the child care facility or school? □ □

If Yes, please explain:____

(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or educational needs? □ □

If Yes, please explain:____

7. Do you have 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:____

____

PARENT'S STATEMENT - ALL MUST 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 NEED AT KIDDIE ACADEMY.

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 Greenlawn

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

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. 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:________________________________

3. 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:________________________________
4. 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:________________________________
5. This child requires a modified diet and/or special feeding procedures. ___YES ___NO

   If YES, please specify:________________________________
6. Does this child have any limitations that would effect full participation at the center? ___YES ___NO

   If YES, please specify:________________________________
7. Does child's physical activity need to be restricted? ___YES ___NO

   If YES, please specify:________________________________
8. Does this child require any specialized treatment? ___YES ___NO

   If YES, please specify:________________________________
9. Does this child require any adaptive equipment (Braces, crutches, etc.)? ___YES ___NO

   If YES, please specify what type:________________________________

   Special instructions for use:________________________________
10. Additional comments:________________________________

    ____

I CONDUCTED A PHYSICAL EXAMINATION OF THE ABOVE-NAMED CHILD ON ___________ AND FIND
Date

THAT HE/SHE _IS / IS NOT_ MEDICALLY CLEARED TO ATTEND KIDDIE ACADEMY.
(Circle One)

________________________________ (________)________________

Name of Health Practitioner (Please Print) **Telephone Number**