The Kidz Garden

Student Health History

Student's Full Name	DOB
Date of last PHYSICAL EXAM	Date of last VISION TEST
Date of last HEARING EXAM	Date of last DENTAL EXAM
Does this student require adaptive devices? If yes, please indicate (Wheelchair) (Glasses) (Hearing aid) (Prosthetic limbs) (Other Please indicate)	
List any allergies, the symptoms and types of response required for allergic reaction.	

Please circle all that apply please explain on back include date diagnosis and treatment

Does the student have any of these problems with any of the following conditions?	
AIDS/HIV Amputation Or Prosthetic Limbs Bladder Or Bowel Control Caner Chicken Pox Convulsions Or Seizures COVID Diabetes Digestive Problems Eating Disorders Eczema Or Skin Problems Fainting Spells	Frequent Colds Hand Foot & Mouth Disease Hearing Or Speech Problems Hepatitis Heart Trouble Lung Or Breathing Problems Premature @ _____ wks RSV Strep Throat Tuberculosis Vitamin/Mineral Deficiency Vision Problems
Is the student CURRENTLY, Under a doctor's care? if yes please explain	
Has the student ever been hospitalized or had any operations? If yes, please explain.	
Is the student on continuous medication? If yes, please explain.	
Does the student have any physical or mental disabilities? If yes, please explain.	
Has the student had any injuries with fractures or loss of consciousness? If yes, please explain.	
List any other members of the student's family with serious chronic conditions.	
Share any information that directly can assure safe medical treatment for the student.	

For any student with health care needs such as allergies asthma or other chronic conditions that require specialized health services and medical action plan shall be attached to this form. The medical action plan must be completed by the student's parent/guardian or healthcare professional. The medical action plan must be updated as changes occur and on an annual basis.

Parent/Guardian 1 Signature	Date
Parent/Guardian 2 Signature	Date
Director Signature	Date