# *Kasha Academy*

## CONFIDENTIAL HEALTH INFORMATION

Name:_____ Date: _____
First MI Last

Birthdate: _____ Sex: □ M □ F School: _____ Grade: ____

**ALERT TO PARENTS:** If your child has a serious medical condition*, it is vital that you discuss this with the director*.

This information is pertinent in order to provide a safe and healthy environment for your child.

**A. MEDICAL HISTORY:** Check the ones that apply to your child and describe under the comment section.

_____ ADD/ADHD
_____ Anxiety/Panic attack
_____ Asthma
_____ Bee Sting allergy
_____ Bowel problem
_____ Cerebral Palsy
_____ Color Blindness
_____ Diabetes
_____ Epi-Pen

_____ Emotional Concerns
_____ Headaches
_____ Hearing Problem
_____ Heart Condition
_____ Kidney/urinary problems
_____ Muscle Disorder
_____ Neurological Concern
_____ Orthopedic problem
_____ Seizures

_____ Vision problems
_____ Other:_____
_____

_____ PE activity
Limited:_____
_____
Explain:_____
_____

Comments: _____

**B. ALLERGIES:** List allergies your child has that cause a problem at school:

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

**C. MEDICATION**: (Include prescription, over-the-counter and herbal medication.)

| Name | Used to treat |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

**D. List any other operations, injuries, hospitalizations and give dates:** _____
_____

**E.** Does your student wear contact lens? _____ Glasses? _____

**F.** Name of Physician: _____ Phone: _____
Name of Dentist: _____ Phone: _____

**IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:**
Name: _____ Home phone: _____ Cell phone: _____

**G. Certification of Immunization** (to be completed by a physician, nurse practitioner or health department official)

| IMMUNIZATION | Record Complete Dates (month, day, year) of vaccine doses given | | | | |
|---|---|---|---|---|---|
| Diphtheria, Tetanus, Pertussis (DTP, DTap) | 1 | 2 | 3 | 4 | 5 |
| Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | 1 | 2 | 3 | 4 | 5 |
| Poliomyelitis (IPV, OPV) | 1 | 2 | 3 | 4 | |
| Haemophilus influenzae Type b (Hib conjugate) | 1 | 2 | 3 | 4 | |
| Pneumococcal (PCV conjugate) | 1 | 2 | 3 | 4 | |
| Measles, Mumps, Rubella (MMR vaccine) | 1 | 2 | | | |
| Measles (rubeola) | 1 | 2 | Serological Confirmation of Measles Immunity: | | |
| Rubella | 1 | 2 | Serological Confirmation of Rubella Immunity: | | |
| Mumps | 1 | 2 | | | |
| Hepatitis B Vaccine (HBV) | 1 | 2 | 3 | | |
| Varicella Vaccine | 1 | Date of Varicella Disease: | | | |
| Other | 1 | 2 | 3 | 4 | 5 |

I certify that this child is ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED in accordance with the minimum requirements for attending school, daycare or preschool prescribed by the State Board of Health's Regulations for the Immunization of School Children.

_____ _____
Parent or Guardian Signature Date

_____ _____
Signature of Medical Provider or Health Department Official Date