Capital Kids Preschool

Where Minds Grow

HEALTH FORM

Child's Name_____ _____
Last **First** **Middle** **Birth Date**

Name of Parent or Guardian _____ _____
Relationship

Home Address _____

_____

Check Best Telephone Number to Reach You:

☐ **Home#:**_____ ☐ **Work #:**_____ ☐ **Cell#:** _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

PLEASE RETURN THIS COMPLETED FORM TO:

CAPITAL KIDS PRESCHOOL

20 NIGEL PHILIP AVENUE EASTLEA HARARE

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN** **CHILD'S NAME: _____**

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	_____	_____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	_____	_____
Date of last eye examination:_____/_____/ _____ Doctor's Name: _____		
Results: _____		
Does your child wear glasses?	_____	_____
Contact lenses?	_____	_____
3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	_____	_____
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.*)?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:	_____	_____
(a) Does this condition require any special health care in the child care facility?	_____	_____
(b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?	_____	_____
(c) Does your child require any special adaptations or adaptive equipment?	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

REMARKS (*Provide further explanation for all "YES" answers):* _____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____ _____

Signature of Parent/Guardian **Date**

PART II: MEDICAL INFORMATION

HEALTH PRACTITIONER **CHILD'S NAME:** _____

1. This child has the following which may significantly affect his/her child care experience: (COMMENTS)
   a. Vision problem DYES D NO _____
   b. Hearing problem DYES D NO _____
   c. Speech or language problem DYES D NO _____
   d. Other physical illness or impairment DYES D NO _____
   e. Mental, emotional or behavior problems DYES D NO _____
   f. Developmental delays DYES D NO _____
   g. Allergies DYES D NO _____

   Significant physical findings, comments and recommendations: _____

2. This child has a health condition which may require care or emergency action while at child care. DYES D NO

   If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

   Recommendations: _____

3. 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.

   DYES D NO If YES, please specify: _____

4. This child requires a modified diet and/or special feeding procedures. DYES D NO

   If YES, please specify: _____

5. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

   _____

6. Does this child's physical activity need to be restricted? DYES D NO

   If YES, please specify: _____

7. Does this child require any specialized treatment? DYES D NO

   If YES, please specify: _____

8. Does this child require any adaptive equipment (braces, crutches, etc.)? DYES D NO

   If YES, please specify type: _____

   Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types Enter: Month/Day/Year for each immunization administered												
Dose #	**DTP-DTAP**	**Polio**	**HIB**	**Hep B**	**PCV7**	**MMR**	**Varicella**	**Rotavirus**	**MCV4**	**HPV**	**Hep A**	**Other**
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a □ permanent □ temporary condition until / / . Check appropriate box, indicate vaccine(s) and reasons: _____

_____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care.

(circle correct response)

_____	_____	_____
Signature of Health Practitioner	**Date**	**Phone Number**

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Eastlea, Harare
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Web: www.capitalkids.co.zw