CHAI PRESCHOOL ORLANDO

7504 Universal Blvd.
Orlando, FL 32819

B"H

For Office Use

Year

Bunk

Name

Health History Form for Children attending Chai Preschool Orlando

Developed with the American Academy of Pediatrics.

Name _____ Birth date _____ Age ____
Last First Middle

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender: ☐Male ☐Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street address City State Zip

Business address _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

▶**Photocopy of front and back of health insurance card must be attached to this form.**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted.

I hereby give permission to the school to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral billing, or insurance purposes. I give permission to the school to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photo-copied for trips out of school.

Signature of parent or guardian _____

Printed Name_____ Date _____

Important - These boxes must be complete for attendance*

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

Fax to: 877.835.6090 or Mail To Chai Preschool, PO Box 690282, Orlando, FL 32869

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Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:
Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.

_____

MEDICATIONS BEING TAKEN

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ☐ Red meat ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe)_____
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

1. Had any recent injury, illness or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness or condition?	☐	☐	17. Ever had problems with joints? (e.g. knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4. Ever had surgery?	☐	☐	19. Have any skin problems? (e.g. itching, rash, acne)?	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed-wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which professional help was sought?	☐	☐
14. Ever had high blood pressure?	☐	☐			
15. Ever been diagnosed with a heart murmur?	☐	☐			

_____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	**Yes**	**No**		**Yes**	**No**

Please explain any "yes" answers, noting the number of the questions. _____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the school should be aware.

_____

Name of family physician _____ Phone _____

Address _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Screening Record ***(For school use only)*** Screened by _____

Date Screened _____ Time _____ am pm Updates/additions to health history noted ☐ Yes ☐ No ☐ None required
Meds received _____
Current health needs identified _____
Observational notes _____
_____

PLEASE ATTACH A CURRENT MEDICAL FORM SIGNED BY CHILD'S DOCTOR.