OFFICE/STAFF SECTION:
Date in from Parent: _____
Date reviewed by Director _____
Initial Registration. Yes / No
Re-registration: Yes / No

Student Health Screening

Privacy Act Statement
Principle Purpose: To determine needs for children and youth in our care.
Disclosure: Disclosure of requested information is voluntary; however, if information is not provided, the individual may not be able to be enrolled in or participate in Knollwood Christian Academy Daycare.

Student's Name: _____ Student's Date of Birth: _____ Age: _____

Student Health Screening

Part A - Identification of Child Conditions/Restrictions

Does your child have any of the following conditions/restrictions: (circle yes or no and answer questions as appropriate)

1. Allergies Yes / No
    a. List allergy: _____
    b. Reaction: _____
    c. Life threatening reactions? Yes / No
    d. Rescue Medication (Epi-pen, Benadryl, Inhaler)? Yes / No
    e. List Rescue Medication: _____
2. Dietary Needs Yes / No
    a. Is your child on a complex diet (i.e. gluten free, diabetic, etc.)? Yes / No
    b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance, etc.)? Yes / No
    c. Does your child have a dietary religious restriction? Yes / No
3. Asthma/Airway Disease/Breathing Problems? Yes / No
    a. Does your child need a rescue med? Yes / No
    b. List rescue medication: _____
4. Does your child have diabetes? Yes / No
5. Does your child have seizures? Yes / No
    a. Does your child need a rescue med? Yes / No
    b. List rescue medication: _____
6. Attention Deficit Disorder (ADD/ADHD) Yes / No
    a. Are there behavior/conduct concerns while on meds? Yes / No
    b. List ADD/ADHD medication: _____

7. Behavioral/ Conduct Concerns (ODD, anxiety, depression, bipolar, other)? Yes / No
   a. List concern: _____
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) Yes / No
   a. List disorder: _____
9. Does your child have any of the following health concerns? (circle all that apply)
   a. Hearing impairment/ vision impairment (other than corrective lenses), heart, kidney, physical disability, SEVERE skin condition
   b. Please specify: _____
10. Does your child have a speech/ language and/ or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? Yes / No
   a. Please explain: _____
11. Does your child have developmental delays other than MILD speech language/ hearing loss? Yes/ No
   a. Explain: _____
12. Are there any other conditions or concerns that you would like staff to be aware of? Yes / No
   a. Explain: _____

Part B- Medications

List any medications that are prescribed for your child other than those listed above:

_____

Will your child require medication administration during child care supervision hours? Yes / No

Part C – Early Intervention and Special Education

Does your child receive special services/ therapies? Yes / No

Please specify: _____

Does your child have an Individualized Education Plan (IEP)? Yes / No

Part D – Signature

Please sign indicating that the information above is accurate and complete to the best of your knowledge.

Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Awaken Christian Academy Daycare strives to provide the safest and healthiest environment for your child and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended and terminated if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child's health please notify Awaken Christian Academy Daycare Directors immediately.