teach, explore, inspire... green.™

kidz go eco LLC

HEALTH HISTORY

Must provide a copy of current doctor's immunization records.

Child's Name: ______________________ DOB: ___ /___ /______ Age: __________

Name of Parent/Guardian: ______________________________________

Address: ______________________ City: __________ State: _____ Zip Code: ________

Phone: ______________________________________

MEDICAL SUMMARY

Male:_______ Female:_______

Height: ________ Weight: ________ Pulse: ________ Blood Pressure: ______ /______

List any diagnosis or health concerns (asthma, allergies, diabetes, chronic illness, seizures, etc):

____

____

Has the child ever had a sever reaction to anything (peanuts, bee stings, etc.)?

____

If yes, please explain including whether the child needs an Epi-pen at school.

____

List any current or prescribed medications and dosages:

____

List any past hospitalizations, surgeries or injuries (ear infections, placement of tubes, tonsillectomies, etc.): ______________________________________

Please outline any family medical history that might be important for the school to know:

____

List any speech/language or motor development concerns that you or the parents have:

____

teach, explore, inspire... green.™

kidz go eco LLC

HEALTH HISTORY (PG 2)

Must provide a copy of current doctor's immunization records.

MEDICAL SUMMARY *CONTINUED*

Hearing Screening: L-Ear 500 - 1000 - 2000 - 4000 R-Ear 500 - 1000 - 2000 - 4000

History of: Ear Infections ________ Hearing Loss ________ Fluid in Ears ________

Vision Screen: L 20/_____ R 20/_____ Both 20/_____ Glasses _____ Contacts _____ Color Vision _____

Please check if abnormal and comment:

___ Skin: ______________________

___ Eyes: ______________________

___ Lymphatic: ______________________

___ Genitalia Hernia: ______________________

___ Chest: ______________________

___ Mouth & Dental: ______________________

___ Ears: ______________________

___ Abdomen: ______________________

___ Orthopedic: ______________________

___ Heart: ______________________

Significant findings and physician's recommendations to parents and teachers:

____

____

Other Comments:

____

____

____

Recommendations for Physical Education: ________ Full Program ________ Restricted ________

If marked *Restricted*, please explain: ______________________

Date: ____ /____ /________ Doctor's Signature: ______________________

teach, explore,
inspire... green.™

kidz go eco LLC

EVIDENCE BLOOD LEAD TESTING

Child's Name: ______________________________ DOB: ____ /____ /________

RECEIPT OF TEST

Received a venous/capillary blood lead test on: ______________________ Date: ____ /____ /________

Test was administered by: (signature of medical provider) ______________________________

Medical provider address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________

REFUSAL OF TEST

I verify that I have been made aware of the serious long-term health effects of lead poisoning on children under the age of six years. I object to my child being blood tested in order to determine if he/she is lead poisoned.

Reason for refusal: ______________________________

Signature: ______________________________ Date: ____ /____ /________

Relationship to child: ______________________________

Parent/Guardian Address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________