# AKD KIDS STUDENT MEDICAL REPORT

**Student's Name:** _____

**Date of Birth:** _____

**Gender:** _____

**Blood Type:** _____

**Height:** **Weight:** **Hair Color:** **Eye Color:**

**1.** Special medical conditions_____
**2.** Chronic illnesses_____
**3**. History of serious injuries or hospitalizations of which we should be aware
_____
**4.** Diabetes □ Yes □ No
**5.**Medication that will be administered regularly at school _____
**6.** Special dietary needs_____
**7.** Physical Restrictions_____
**8.** Is your child able to fully participate in all of the activities offered by AKD KIDS? □ Yes □No
**9.** Can your child effectively communicate his or her needs? □ Yes □No
**10.**Does your childrequire any assistance at mealtime? □ Yes □No
**11.**Does your child rest in the middle of the day? □ Yes □No
**12**.Is your child toilet trained? □ Yes □No

**Please note if your child had any of the diseases listed below**

| | **Date** |
|---|---|
| □Bronchiolitis/pneumonia | _____ |
| □Chicken Pox | _____ |
| □**Hepatitis** | _____ |
| □**Scarlet Fever** | _____ |
| □**Measles Rubella** | _____ |
| □**Rubella** | _____ |
| □**Mumps** | _____ |
| □**Pertussis(Whooping Cough)** | _____ |
| □**Other serious Illness** | _____ |

**ALLERGIES**
□Medications _____ Reaction _____
□Food _____ Reaction _____
_____
□Respiratory _____ Reaction_____
□Bee Sting _____ Reaction _____
□Other_____ Reaction _____

## STUDENT'S MEDICAL CARE PROVIDER/ FACILITY

**Student's Doctor Name: _____ Clinic Name:_____**

**Doctor's address: _____**

**Preffered Hospital/ Clinic for emergency care: _____**

**Dentist Name: _____**

**Address: _____**

**Private Health Insurance Provider and Policy Number: _____**