



Student Health Record

Name: _____ Birthdate: _____ Gender: _____
(last name) (first name) (middle) (year) (month) (day)

Father's name: _____ Address: _____

Mother's name: _____

Home phone: _____ Name of Siblings at KAS and grade level: _____

Email: _____

Business phone: _____
(father) _____
(mother) _____

Mobile Number: Father _____ Mother: _____

Emergency Contact if unable to reach parent: _____
(name) (phone number)

Health History

Did your child have any problems at birth or during the pregnancy?

Yes _____ No _____ If yes, please explain.

Any delays in child's developmental milestones (such as walking, talking, etc.) Yes _____ No _____

If yes, please provide details: _____

Disease History (give age):

Health Problem/Doctor Diagnosed (give age):

Rheumatic Fever	Mumps	Allergy	Visual Problems
Chicken Pox	Scarlet Fever	Asthma	Hearing Loss
German Measles	Chronic Ear Infections	Heart Disease	Seizure Disorder
Measles	Urinary Tract Infection	Diabetes	Orthopedic
Other		Other	ADD/ADHD

Any allergies (food, environment, medications)? Yes _____ No _____ If yes, describe reaction, treatment, and medications taken: _____

Describe any serious illnesses, operations, injuries, or hospitalizations: _____

Detail any other medical concerns: _____

Medications taken on a regular basis: _____

I am providing a true copy of my child's immunizations to KAS and will provide timely updates as required by school policy. I understand this is part of the condition of enrollment at KAS.

(parent signature)

(date)