Keystone Kids Health History

Name_____ Birth Date _____
Height and Weight _____ SS# _____-_____-_____
Sex: male / female Eye Color _____ Hair Color _____
Is your child currently taking any prescription medication? Yes/ No
If yes, please indicate the name of medication(s) and schedule:

_____
_____
_____

Please list any over the counter medications your child may NOT have (Tylenol, tums, etc.)_____
Indicate if your child has a history of the following (if yes, please explain):
Hospitalizations/Operations _____
Serious Illness/accidents _____
Allergic Reactions _____
Describe reaction _____
Medication necessary? Epipen, Benadryl, other:_____
Hay Fever/Allergies _____
Bronchitis _____
Asthma _____
Diabetes _____
Heart Problems _____
Kidney Problems _____
Seizures _____
Ear Infections _____
Vision Problems _____
Hearing Problems _____

Are there any other physical problems concerning your child?

_____
_____
_____

Are there any emotional problems we should be aware of concerning your child?

_____
_____
_____

Please list any additional information we should know:

_____
_____
_____

**I grant permission to share this health information with necessary staff in the care of my child.

Parent Signature _____ Date _____