KIDS OF THE KINGDOM
EPISCOPAL SCHOOL

11093 Bandera Rd. San Antonio, TX 78250
Office: 210-688-9171

CHILD'S HEALTH STATEMENT

Child's Name_____**Sex**_____**Birthdate**_____

PLEASE BE ADVISED: Doctor's Statement must be signed and a current copy of your child's shot record on file, before your child may begin the program. All immunizations must be kept up to date or your child will be excluded from attendance.

DOCTOR'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

_____ _____
Physician's Signature **Date**

***Hearing & Vision Screenings are required for children enrolled in the 4 year old classes. Results may be recorded on the back of this form.**

PARENT/GUARDIAN: Please write **yes** or **no** to all special problems or needs listed below. If your answer is yes, please explain in detail.

CONDITION	WRITE YES OR NO	IF YES EXPLAIN IN DETAIL
FOOD ALLERGIES		
ASTHMA		
ALLERGIES		
EXISTING ILLNESS		
PREVIOUS SERIOUS ILLNESS		
INJURIES & HOSPITALIZATIONS DURING THE PAST 12 MONTHS		
ANY MEDICATION PRESCRIBED FOR LONG-TERM CONTINUOUS USE		
DISABILITIES/SPECIAL NEEDS		
ANY OTHER INFORMATION WHICH STAFF SHOULD BE AWARE OF		

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____
Signature – Parent or Legal Guardian **Date**

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FOUR YEAR OLDS ONLY

Child's Name_____Sex_____Birthdate_____

Visual acuity and hearing sensitivity screening are required only for children enrolled in the 4 year old classes. Rescreening is only required if an abnormality was noted on the first screening. Speech screening is optional (not required).

SPECIAL SENSES SCREENING RECORD

HEARING SCREENING:

1ST

at 25dB	R	L
500 Hz		
l000Hz		
2000 Hz		
4000 Hz		

Pass_____
Fail-Rescreen_____
Date_____

_____
Signature

2ND

at 25dB	R	L
500 Hz		
l000Hz		
2000 Hz		
4000 Hz		

Pass_____
Fail-Refer_____
Date_____

_____
Signature

VISION SCREENING:

1ST

DISTANCE ACUITY: R-20/_____ L-20/_____

PASS_____

FAIL-RESCREEN_____ _____
DATE

_____
Signature

2ND

DISTANCE ACUITY: R-20/_____ L-20/_____

PASS_____

FAIL-REFER_____ _____
DATE

_____
Signature

SPEECH SCREENING (OPTIONAL):

NAME OF TEST: _____

☐ **PASS** ☐ **FAIL**

_____ _____
DATE **SIGNATURE**