State of Israel
Ministry of Education

Health declaration of their child in kindergarten

The name of the kindergarten:_____ **Address:**_____

To kindergarten teacher – director (Name):_____

From the Parents of the student:

Last name:_____ **First name of the student:**_____

ID number:_____ **Date of birth:**_____

1. **I declare that (fill the appropriate option)**

☐ There is no health limitation that prevents my **son/ daughter** from participating in kindergarten activities and on is behalf.

☐ My **on/ daughter** has health limitations that prevent full or partial participation in activities held in kindergarten and on his behalf, **see details below:**

- ☐ Physical activity
- ☐ Trip
- ☐ Other activities

Description of the limit: _____

***A medical document detailing the student's limitation should be attached to this form.**

The medical document given by:_____

Certificate validity: from_____ to _____

Contains protected information under the Privacy Protection Law – unlawfully removed from an offense

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2. Does your **son/ daughter** have a chronic health problem? **Yes / No**

☐ Asthma	☐ Bowel Disease - Crohn's Disease	☐ Celiac
☐ epilepsy	☐ Bowel disease – Colitis	☐ Blood clotting - hemophilia
☐ Cardiological problem	☐ Dermatosis	☐ Blood clotting - trombocytopenia
☐ Transplanted Organ	☐ Muscular Dystrophy- Duchenne	☐ G6PD
☐ Malignant disease- chemotherapy treatment	☐ Juvenile sukkah of type 1 Juvenile diabetes	☐ Another chronic problem

***A medical document detailing the student's limitation should be attached to this form.**

details: _____

_____

3. Does the student regularly take medication? **Yes/No**

details: _____

4. Is the student susceptible to medication? **Yes / No**

details: _____

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5. Is your **son/ daughter** student sensitive to food or other substances? **Yes / No**

details: _____

☐ Nut	☐ Milk	☐ Wasps sting	☐ Yeast
☐ Peanuts	☐ iodine	☐ fava beans	☐ Almond
☐ Eggs	☐ Latex	☐ Plants (pollen)	☐ Other material/food
☐ soybeans	☐ Kiwi	☐ Gluten (wheat)	
☐ Honey	☐ Sting Bees	☐ Credit House Dust	
☐ Fish	☐ Sesame	☐ Mosquito Bite	

details: _____

* If necessary and on a doctor's recommendation, carry a personal EpiPen syringe.

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6. Does your **son/ daughter** carry a personal EpiPen syringe: **Yes/No**
*A medical document from a specialist physician must be attached.**

7. I am responsible for ensuring that the kindergarten staff is instructed on the first aid required for the student in the event of an emergency due to (This section applies only to children indicated to have a health problem).

Student Health Services:

8. I confirm that as part of the health services, my **son/ daughter** will pass medical Examinations and training:

☐ **Lazy eye vision (Amblyopia) test-** Non-invasive testing. The parents of the children will be notified explicitly prior to the date of the test in their kindergarten.

☐ **Dental Health -** Some kindergartens run a tooth decay prevention program through guided Tooth brushing. **Parents of children in the kindergartens where the program will take place will be notified explicitly.**

9. In case of a medical problem we will contact:

Full name: _____ Phone number: _____ relationship_____
Full name: _____ Phone number: _____ relationship_____

I authorize the provision of relevant information to the educational staff and/or the health team at the kindergarten regarding the student's health and undertake to notify the class educator of any change or limitation, temporary or permanent, that will apply in his health condition.

Name of the parent: _____ I.D: _____
Signature: _____ Date: _____

***If the parents are separated or divorced, each parent's signature is required**

Name of the parent: _____ I.D: _____
Signature: _____ Date: _____