

# MONTGOMERY MONTESSORI SCHOOL

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## Health Form

TO BE FILLED OUT BY PARENT/GUARDIAN

Birth Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_

**In an effort to provide a safe, healthy environment for your child at school, we would like to know about your child's health needs.**

1. Have there been any major changes in the family situation in the last year, such as a family moving, loss of someone close, serious illness in the family, or something else? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:

2. Does your child have a disability? Yes \_\_\_\_ No \_\_\_\_  
If yes, do you feel your child has special educational needs?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:

3. Has your child had any serious accidents, illnesses, hospitalizations or injuries in the past year? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:

4. Please describe any health concerns or medical diagnoses your child may have (i.e., asthma, seizure disorder, diabetes, hearing or vision problems or any health concern).

5. Does your child take any medications regularly? Yes \_\_\_\_ No \_\_\_\_ If yes, please list:

6. Please describe any additional comments information that you would like to share about your child's health.

May this information be shared with appropriate school personnel? Yes \_\_\_\_ No \_\_\_\_

If your child has a health concern, may this information be included on a health concern list that is maintained in the school office. Yes \_\_\_\_ No \_\_\_\_

**Signature of Parent of Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

(turn over please)

**TO BE FILLED OUT BY YOUR PRIMARY PHYSICIAN**

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Vision: Acuity \_\_\_\_\_

Hearing: Audio gram \_\_\_\_\_

Please describe any significant disabilities, developmental concerns or abnormal finding which would be helpful for the nurse to know about when providing care in the schools.

Do you feel this child has special educational needs ? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

Is this child on any routine or long term medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

Is this student capable of carrying a full program of school work, including physical education? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please give reason

**Date** \_\_\_\_\_ **Physician's Signature** \_\_\_\_\_