Academy Montessori Internationale

PARENTS ARE TO COMPLETE THIS FORM

CHILD'S NAME _____ GENDER M F OTHER _____

DATE OF BIRTH _____ DATE ADMITTED _____
(MM/DD/YYYY) (MM/DD/YYYY)

PARENT/GUARDIAN NAME _____ PARENT/GUARDIAN NAME _____

ADDRESS- HOME _____ CITY _____ ZIP CODE_____

PHONE NO. HOME _____ PRIMARY CELL M / D _____ SECONDARY CELL M / D _____

NAMES & AGES OF CHILDREN IN FAMILY _____

_____

MEDICAL INFORMATION

HOSPITAL PREFERENCE (FOR EMERGENCIES) _____

CHILD'S PHYSICIAN _____ PHONE NUMBER _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS? IF SO, PLEASE EXPLAIN _____

A. ALLERGIES Y N _____
B. FREQUENT SORE THROAT/COLD Y N _____
C. EARACHE Y N _____
D. SKIN PROBLEMS Y N _____
E. DIETARY NEEDS NON VEG VEG SPECIAL INSTRUCTION _____
(CIRCLE ONE)
F. OTHER _____

LIST OF ANY CHILDHOOD DISEASES OR OTHER ILLNESSES YOUR CHILD HAS HAD _____

_____

HAVE THERE BEEN ANY MAJOR CHANGES AT HOME THAT MIGHT AFFECT YOUR CHILD IN CARE? Y N _____

_____

IS THERE ANY SPECIAL INFORMATION THAT WOULD HELP THE PERSON CARING FOR YOU CHILD? Y N _____

_____

I GIVE PERMISSION TO THE SCHOOL PROVIDER TO ADMINISTER NON PRESCRIPTION MEDS, SUCH AS: ACETAMINOPHEN, TYLENOL, COUGH SYRUP, COUGH DROPS OR OINTMENTS Y N EXPLAIN _____

****PLEASE ATTACH A COPY OF THEIR CURRENT IMMUNIZATION RECORDS TO THIS FORM.**

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CHILD'S NAME_____

THIS SIDE SHOULD BE COMPLETED AND SIGNED BY A NURSE APPROVED TO PERFORM HEALTH ASSESSMENTS OR A LICENSED PHYSICIAN

TO BE KEPT IN THE FACILITY

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____

PHYSICAL EXAMINATION HEIGHT _____ WEIGHT _____

HEAD _____ ABDOMEN _____

EENT _____ GU _____

TEETH _____ GYN _____

HEART _____ SKELETAL _____

LUNGS _____ NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS)

VISION _____ TBC TEST _____

HEARING _____ SICKLE CELL _____

SPEECH _____ HGB _____

DDST _____ U.A._____

OTHER _____

DIAGNOSIS:

RECOMMENDATIONS:

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? YES _____ NO _____

_____ _____

SIGNATURE DATE