blue mountain MONTESSORI

Physician's Health Form

Parent Please Complete

Name of Child: _____ Date of Birth: _____

Parent 1 Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent 2 Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

History of Disease and Health Information

☐ Chicken Pox ☐ Measles/Mumps/Rubella ☐ Influenza ☐ Chronic Ear Infections

☐ Tuberculosis ☐ Pertussis ☐ Streptococcus ☐ Hospitalization

Allergies or Special Diet Needs _____

Chronic Health Conditions _____

Developmental Concerns _____

Physician Please Complete

General Health Appraisal

Verify above information, and indicate child's most recent comprehensive physical exam _____

To your knowledge has child received all age-appropriate medical examinations and immunizations? _____

Is there any reason to suspect that this child either cannot or will not perfrom as would any other child in good physical condition and in similar circumstances?

_____

Remarks or Recommendations _____

Physician's Signature _____ **Date** _____