CHILD HEALTH FORM

To Be Completed by Parent or Guardian:

LAST NAME _____ FIRST NAME _____ M.I ____ DOB: ___/___/___ MO DAY YEAR ____ BOY ____ GIRL

_____
CHILD'S ADDRESS

We/I _____ give permission to obtain or release necessary information on the above child.

Please return to: Mnt. View Montessori School P.O. Box 495, Intervale, NH 03845
Fax 356-9716 M-F 7a.m to 2:00 p.m.

HISTORY: To Be Completed by Physician (This information will be held confidential and will be used only for the benefit of this child).

A Prenatal, perinatal and postnatal development: Any significant findings that could influence this child's adaptations to a child care setting (i.e., physical handicap, sensory loss, developmental irregularities)?

B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (e.g., recurrent ear infections, seizure disorder, allergies)?

C. Any hospitalizations, operations, or special tests of which a child care provider should be aware?

D. Pertinent family, social or health characteristics?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE

You May Substitute A Copy Of Your Own Immunization Record

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTaP						
Hib						
DTP-Hib						
Td						
OPV or IPV						
MMR						
Hep-B						
Varicella (Recommended)						
Other						

Communicable Disease History / **Recommended Screening & Testing of Attendees**

Disease	Date of Diagnosis	Laboratory Confirmation	Physician		Date	Method	Result:
Chickenpox		Not Applicable		TB (For High Risk Children Only)			
Other:				Vision			
				Hearing			
				Speech			
				Hbg/HCT		Not Applicable	
				Urine		Not Applicable	
				Lead		Not Applicable	