HEALTH REPORT

CHOICE OF EXAMINER: It is recommended that each child have a personal physician knowledgeable regarding each aspect of his/her health. Examination may be performed by a licensed physician (M.D. or D.O.), a licensed physician's assistant, or a certificated pediatric or family nurse practitioner working under the direction of a physician whose name is to be stated.

THIS SECTION IS TO BE COMPLETED BY THE PARENT OR GUARDIAN BEFORE EXAMINATION BY THE PHYSICIAN. PLEASE PRINT.

Montessori in Motion

Last Name | First | Middle | Birth date: Month–Day–Year | Sex | Name of School

Name of Parent or Guardian | Address | Zip | Home Phone | Work Phone

Usual Physician or Source of Health Care | Phone | Dentist | Phone

CHECK PURPOSE OF REPORT - SCHOOL: ☐ Preschool, ☐ Kindergarten, ☐ Elementary School. To enter grade____ September 20____

IS THERE ANY ILLNESS OR HANDICAP, or other situation which might affect performance? (Please explain)

CHILD HAS OR HAD THE FOLLOWING: Circle the appropriate Item(s) and explain on the right. Name other doctors important in child's care.

SKIN: acne, eczema (problems with skin rash), ringworm, head lice, impetigo

VISION: glasses, contacts

HEARING: aids, frequent ear Infections

NOSE: bleeding

MOUTH: dental decay, orthodontia, frequent sore throats

LUNGS: asthma, bronchitis

HEART: congenital, rheumatic

GENITOURINARY: kidney or bladder infection

HAS CHILD HAD: ☐ rubeola ☐ rubella ☐ mumps ☐ chicken pox ☐ whooping cough ☐ poliomyelitis ☐ scarlet fever ☐ tuberculosis

GASTROINTESTINAL: ulcer, colitis, hepatitis, stomach upsets, problems with diarrhea, constipation or soiling

ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip

NEUROLOGICAL: convulsions, meningitis, cerebral palsy,fainting spells, epilepsy

METABOLIC: diabetes

BLOOD: anemia, sickle cell disease

DIETARY RESTRICTIONS (medical and personal)

ALLERGIES: food, insect, pollen, contact, drugs, other – Specify

HOSPITALIZATION(S): (year and reason)

OPERATION(S): (year and reason)

HANDICAP: physical, mental, behavioral, social, learning, vision, hearing, speech, hyperkinesis

If child is under 3 years, give birth weight _____ Describe unusual factors regarding birth or health immediately after birth _____

I certify that to the best of my knowledge the information given above is accurate.	Signature of Parent or Guardian	Date

THIS SECTION IS THE RESPONSIBILITY OF THE PHYSICIAN. PARENT(S) SHOULD BE PRESENT FOR EXAMINATION.

Date of examination | Height | Weight | Blood pressure | Hearing: Right | Left | Hematocrit | Sickle Cell | Hemoglobin | Urinalysis

Vision: Right 20/ Left 20/ | Vision corrected: glasses, contacts Right 20/ Left 20/ | Color Vision *(circle which)* | Tuberculosis skin test: Date | Type | Result

CIRCLE ABNORMAL AREAS, DISCUSS AT RIGHT

Appearance	Scalp	Throat	Neurological	
Development	Head	Chest	Dental	
Nutrition	Eyes	Lungs	Genitalia	
Acne	Ears	Heart	Extremities	
Rashes	Nose	Abdomen	Back (shows no evidence of Kyphosis or Scoliosis)	

An additional narrative report is attached or will be forwarded. ☐ Yes ☐ No

INTERVAL NOTE: Identify any occurrences since examination which could affect participation in school or other activities.

REFERRAL(S) *(Circle)* Eye, Ear, Dental, Orthopedic, Other (describe) _____ Parents need help to obtain: ☐ Yes ☐ No

Please name other doctors involved in care of child:

ASSESSMENTS THAT MAY BE NEEDED IN SCHOOL OR OTHER FACILITY: Hearing, speech, psychology, physical therapy, guidance, learning. If you believe child should be considered for special education, please describe need above.

MEDICATIONS REQUIRED TO BE GIVEN AT SCHOOL OR OTHER FACILITY. Diagnosis _____

Name of medication | Form | Dose | Time | Duration of prescription | Possible effects

RECOMMENDED PHYSICAL ACTIVITY:

☐ Full child care, preschool, school, physical education, aerobics

☐ Swimming

☐ Modified or restricted activity (describe)

A physician's written release is required to resume participation following all illness and/or injury serious enough to require medical care. Give details above.

Date signed	Next recommended date of examination	Physician's Name (***please print***)	Signature and Title