OURKIDS MONTESSORI Medical Record

Name of Child_____ Age_____ Date of Birth_____

MEDICAL HISTORY (To be completed by parent)

1. Previous Hospitalization: ___yes ___no If yes, why? _____
2. Is child allergic to anything? ___Yes___no If yes, what? _____
3. Any previous diseases, illnesses or injuries? ___Yes ___no If yes, what? _____
4. Any operations? ___Yes ___no If yes, what? _____
5. Is child under a doctor's care? ___Yes ___no what_____
6. Does your child have any special care needs? __Yes ___no If yes, what? _____
   (Please note that if your child has a special need that has been diagnosed by a professionally licensed pediatrician/doctor, we must have papers showing the diagnosis and the treatment for their special needs situation and special needs verification form from the office.)
7. Is there any medication prescribed for long-term use? ___Yes ___No **(*If so, please fill out a* Medication Authorization *form and turn in to front office. This form must be updated monthly.*)**
8. Does your child currently take any type of medication? ____ Yes ____ No
9. Please List all of the medications your child is currently taking?

   _____

   _____

***ADMISSION REQUIREMENT:**

6 WEEKS THRU 5 YEARS ONLY!

_____ ***DOCTOR'S STATEMENT:** I have examined the above named child within the past year and find that he/she is physically able to participate in a childcare program.

_____ _____

Physician's Signature Date

IMMUNIZATION RECORDS ARE DUE *UPON ENROLLMENT*

Note: If immunizations conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunizations would be injurious to your child or your family, you must obtain a certificate from your Physician.

SCHOOLAGE ONLY:

PARENT'S STATEMENT: My child is enrolled at _____ public school.

His/Her shot records are current and are on file at the school.

Phone number of school _____

Parent's Signature_____ Date_____

☐ **My child's vision and hearing screening is on file at this school location as well. Parent's Initials __**_____

VISION/HEARING SCREENING: All children ages 4 and up who are not enrolled in a public school must obtain a vision and hearing screening from their physician. A copy must be supplied to the childcare center. Date Received_____.