



# MONTEVISTA MONTESSORI

## Health Form 2008-2009

Name of Student \_\_\_\_\_ Girl \_\_\_\_\_ or Boy \_\_\_\_\_

Last Name                      First                      Middle

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Mother \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Father \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Other responsible person(s) to whom the child may be released: \_\_\_\_\_

Immunization Records = Numbers of doses and dates

DTP							
Polio							
MMR							
Hep B							
Varicella							
Hib							
Tine Test							

Physical Exam: Date \_\_\_\_\_ Statement by Physician \_\_\_\_\_

Impairments \_\_\_\_\_

Allergies/Sensitivities \_\_\_\_\_

Special Care/Restrictions \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

The child shall be given first aid if needed. In case of critical illness or injury, the physician named by the parents shall be called. If parent(s) cannot be contacted in case of emergency, the child will be taken to the preferred hospital or the nearest emergency room.

Preferred Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Preferred Dentist \_\_\_\_\_ Phone \_\_\_\_\_

In case Monte Vista Montessori is not able to reach me, I the undersigned, hereby authorize emergency medical treatment for my child \_\_\_\_\_ and I take the responsibility for the payment of these services and treatment.

Signature of Parent(s) \_\_\_\_\_