MONTEVISTA MONTESSORI

Health Form

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 theses services and treatment.

Signature of Parent(s) _____