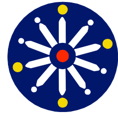

NORTH END
Montessori School

CHILD HEALTH FORMS & IMMUNIZATION RECORD

TO BE COMPLETED BY PARENT OR GUARDIAN

CHILD INFORMATION/RELEASE:

_______________________________ ______ ______/ ______ / ______

CHILD'S NAME (LAST, FIRST) M.I DOB: MO DAY YEAR

_______________________ ______________ ________ ________

CHILD'S ADDRESS CITY STATE ZIP

WE/I GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL HISTORY INFORMATION ON THE ABOVE CHILD TO: North End Montessori School.

(One Signature Required)

____________________________ ______________

PARENT/GUARDIAN SIGNATURE DATE

____

PARENT/GUARDIAN SIGNATURE

PLEASE RETURN TO:

North End Montessori School
698 Beech Street
Manchester, NH 03104
603.621.9011
Fax 603.621.9866

northendmontessorischool@gmail.com

This information will be held confidential and will be used only for the benefit of this child.

TO BE COMPLETED BY PHYSICIAN

CHILD HEALTH & MEDICAL HISTORY/INFORMATION:

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)?

____

____

CHILD HEALTH & IMMUNIZATION RECORD FORM

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

____

____

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

____

____

D. Pertinent family, social or health characteristics?

____

____

Immunizations for Child Care Agency Attendance
Parent may substitute a copy of child's immunization record.

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

Communicable Disease History **Recommended Screening/Testing**

Disease	Date of Diagnosis	Laboratory Confirmation	Physician		Date	Method	Result:
CHICKENPOX		N/A		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER				VISION			
				HEARING			
				SPEECH			
				HIB/HCT	N/A		
				URINE	N/A		
				LEAD	N/A		

CHILD HEALTH & IMMUNIZATION RECORD FORM

TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER

HEALTH ASSESSMENT:

PHYSICAL EXAM:

LENGTH/HEIGHT _______IN/CM %ILE_______	WEIGHT _______LB/KG %ILE_______	HEAD CIRCUMFERENCE _______IN/CM %ILE_______	BLOOD PRESSURE _________/_________

CHECK EACH LINE	NORMAL	AB-NORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE	NORMAL	AB-NORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN /SCALP						CHEST, BREASTS			
NOSE, THROAT, MOUTH						EYE			
NUTRITION						HEART, LUNGS			
TEETH & GUMS						EARS			
NEUROLOGY & MUSCULAR						AB-DOMEN			
GLANDS INC. THYROID						SPEECH			
ORTHOPEDIC & SPINE						GENI-TALIA			

TEMPERAMENT:

EASY-GOING ____ AVERAGE ____ DIFFICULT ____

COMMENTS:

____

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

____

CHILD HEALTH & IMMUNIZATION RECORD FORM

ASSESSMENT OF PHYSICAL DEVELOPMENT:

A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS) EARLY: _____ MID: _____ LATE: _____

B. MID-PRESCHOOL (2-4 YEARS) EARLY: _____ MID: _____ LATE: _____

C. PRESCHOOL (4 YEARS) EARLY: _____ MID: _____ LATE: _____

D. SCHOOL-AGE (6-10 YEARS) EARLY: _____ MID: _____ LATE: _____

E. ADOLESCENT (11-18 YEARS) EARLY: _____ MID: _____ LATE: _____

COMMENTS:
____

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS
GROSS MOTOR				
FINE MOTOR				
LANGUAGE SKILLS				
SOCIAL SKILLS				
EMOTIONAL				

____ __________________

PHYSICIAN'S SIGNATURE DATE OF EXAM

____ __________________

PHYSICIAN'S NAME - TYPED OR PRINTED TELEPHONE NUMBER

____

DATE OF NEXT SCHEDULED EXAM