Casa dei Bambini
Montessori Children's Center

CHILD HEALTH FORMS & IMMUNIZATION RECORD

TO BE COMPLETED BY PARENT OR GUARDIAN

*****NOTE: This form may be substituted with your pediatrician's standard form, provided they are signed by the physician.***

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.
PARENT/GUARDIAN SIGNATURE:_____

DATE: _____

PLEASE RETURN TO:
Casa dei Bambini Montessori Children's Center * 507A South Street * Bow, NH 03304

HISTORY - TO BE COMPLETED BY PHYSICIAN

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

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)?

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 (HIGH RISK ONLY)			
OTHER				VISION			
				HEARING			
				SPEECH			
				HIB/HCT		N/A	
				URINE		N/A	
				LEAD		N/A	

HEALTH ASSESSMENT: ***TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER***

PHYSICAL EXAM:

LENGTH/HEIGHT _____IN/CM %ILE_____	WEIGHT _____LB/KG %ILE_____	HEAD CIRCUMFERENCE _____IN/CM %ILE_____	BLOOD PRESSURE _____/_____

CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN /SCALP					NOSE,THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY &MUSCULAR					GLANDS, INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYES					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERAMENT: EASY-GOING ___ AVERAGE ___ DIFFICULT ___

COMMENTS:

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

ASSESSMENT OF PHYSICAL DEVELOPMENT:

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:

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