MONTESSORI EAST PRE SCHOOL

CHILD'S HEALTH RECORD

Name:	**Birth date:**
Doctor:	**Tel:**
Dentist:	**Tel:**

MEDICAL HISTORY		
Whooping Cough:	Scarlet Fever:	
Rheumatic Fever:	Measles:	
Polio:	Diphtheria:	
Hives:	Chickenpox:	
Mumps:	Convulsions:	
German Measles:		
Hay Fever, Asthma or Eczema:		
Are there any after effects from any of the above?		
Triple Toxoid Dates: 1st:	2nd:	3rd:
Polio Vaccine Dates: 1st:	2nd:	3rd:
Measles Mumps Rubella:		
Other: (specify types and dates):		
Tuberculin Test: Date:	Results: Positive:	Negative:

GENERAL HEALTH INFORMATION	
Any ear infections?	Which ear / s:
Any hearing difficulty?	
Any visual difficulty?	
Any speech difficulty?	
Is elimination satisfactory?	Is control satisfactory?
Bladder?	Bowels?
Any allergies?	
Allergic to any medication?	
Has your child been treated or diagnosed as having any serious illness not listed above?	

FAMILY HISTORY·	
Indicate if any members of your family have had the following:	
Tuberculosis:	Diabetes:
Rheumatic Fever:	
Parent's signature:	Date:

Please attach copy of immunization record.