



WOODLANDHILL
MONTESSORI SCHOOL
100 Montessori Place
North Greenbush, NY 12144
518.283.5400 fax: 518.283.4861

2011-2012 HEALTH REGISTRATION FORM

PARENTS: Please fill out this side of form

NAME OF CHILD (LAST, FIRST, M.I.)		DATE AND PLACE OF BIRTH	SEX	TEACHER'S NAME/GRADE
PARENT(S) NAME(S)				
STREET ADDRESS			CITY/TOWN:	STATE
HOME PHONE	CELL PHONE			

HEALTH HISTORY

Were there any problems noted during pregnancy, at birth, or during early infancy? _____

If yes, please explain _____

Please place a check mark if your child has had any of the following conditions:

Allergies <input type="checkbox"/>	Asthma <input type="checkbox"/>	Ear conditions <input type="checkbox"/>	German measles <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/>
Food <input type="checkbox"/>	Bladder infection <input type="checkbox"/>	Ear infections <input type="checkbox"/>	Heart disease <input type="checkbox"/>	Scarlet fever <input type="checkbox"/>
Drugs <input type="checkbox"/>	Broken bones <input type="checkbox"/>	Emotional problems <input type="checkbox"/>	Heart murmur <input type="checkbox"/>	Scarlatina <input type="checkbox"/>
Other: <input type="checkbox"/>	Chicken pox <input type="checkbox"/>	Enuresis <input type="checkbox"/>	Kidney infection <input type="checkbox"/>	Serious injuries <input type="checkbox"/>
	Contact with TB <input type="checkbox"/>	(bed wetting) <input type="checkbox"/>	Measles <input type="checkbox"/>	Sore throats <input type="checkbox"/>
Reactions: <input type="checkbox"/>	Convulsions <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Night sweats <input type="checkbox"/>	Surgical operation <input type="checkbox"/>
Other: <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Frequent colds <input type="checkbox"/>	Pneumonia <input type="checkbox"/>	Whooping cough <input type="checkbox"/>

If you checked any of the above, please give details and instructions for any care your child may need while attending school. For example: ear infection frequency, severity, how long it lasted, etc.

Do you have any concerns regarding your child, in any of the following areas?:

Attention span <input type="checkbox"/>	Growth <input type="checkbox"/>	Eye sight <input type="checkbox"/>	Learning ability <input type="checkbox"/>	Vision <input type="checkbox"/>
Behavior <input type="checkbox"/>	Diet <input type="checkbox"/>	Hearing <input type="checkbox"/>	Speech <input type="checkbox"/>	Other <input type="checkbox"/>

If you checked any of the above, please explain:

Does your child take any medication regularly? _____ if yes, please list the condition **and** the medication:

When did your child have his/her last dental exam? _____ Dentist's name _____

What work was done? _____

Has your child ever been seen by a specialist (i.e. allergy, orthopedic, eye, psychologist, etc)? _____

If yes, please give doctor's name, date, and details _____

Parent signature _____ Date _____

To be completed by Physician or Mid-Level Practitioner ONLY

NAME of CHILD _____ DATE of BIRTH _____

DATE of EXAM _____

MEDICAL APPRAISAL: (please place an *asterisk* next to an item to provide detail on separate sheet)

Height	Weight	Blood Pressure	Pulse	
Vision O/D 20/	Vision O/S 20/	With or without correction (please circle)		

- Ears
- Hearing
- Eyes
- Nose
- Teeth & gums
- Speech
- Tonsils
- Thyroid

- Lymph nodes
- Heart
- Lungs
- Skin
- Nutritional status
- Hernia
- Nervous system
- Genito-Urinary

ORTHOPEDIC:

- Structural
- Posture
- Feet
- Scoliosis screening

PLEASE ATTACH PROOF of IMMUNIZATION

Acceptable records are certificates of immunization or a signed statement attesting to required immunizations from a physician, or health facility, or fill in the chart below:

Preventative Measures and Tests

Body Mass Index:

	DATE		DATE
DTaP		IPV	
Hib		PCV	
MMR		Varicella (Chicken pox)	
Hepatitis B	#1	#2	#3

Weight Status Category(BMI Percentile)	
__ less than 5 th	__ 85 th -94 th
__ 5 th - 49 th	__ 95 th -98 th
__ 50 th -84 th	__ 99 th -higher

Other measures & tests:

	DATE		DATE
influenza		Tuberculin test	<input type="checkbox"/> positive <input type="checkbox"/> negative
Hep A		Chest x-ray	<input type="checkbox"/> positive <input type="checkbox"/> negative
Sickle cell anemia	<input type="checkbox"/> positive <input type="checkbox"/> negative	Lead level test	<input type="checkbox"/> positive <input type="checkbox"/> negative

Specify Current Diseases:

__ Asthma

Diabetes: __ Type 1 __ Type 2 __

__ Hyperlipidemia

__ Hypertension

__ Other _____

If one or more of the above-required medical immunization(s) is deemed detrimental to this child's health, please attach a signed and notarized letter stating the religious or medical based reason.

Are there any allergies? _____ (if yes, please explain)

Can this child participate in a Physical Education Program? _____

Is there evidence of deterrents to learning? _____ (if yes, please explain)

Are there any additional finding and/or recommendations? _____ (if yes, please explain)

Physician signature _____ Date _____

Physician's name /Address/phone# _____