Montessori School of Fort Worth

SCHOOL HEALTH FORM

Child's Name:		**Birthdate**	/ /

Parent or Legal Guardian must complete and sign the top portion of the health form.

Health Care Professional information	**Dentist information**
Name (please print)	**Name (please print)**
Address	**Address**
Phone	**Phone**

Preferred Hospital:

For governmental reporting purposes, please indicate the ethnicity you prefer for your child:

☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Inter-Racial ☐ Native American ☐ Pacific-Islander ☐ White/Caucasian

List any physical limitations your child may have, such as vision, speech, hearing, etc.:

_____

List any medical conditions, such as asthma, allergies, etc. Circle appropriate response/s: **Intermittent Mild Moderate Severe**

Epi Pen required: **Yes No**

Does your child have a developmental, emotional or behavioral condition that may affect his or her educational experience? **Yes No**
If yes, please explain:

_____

Does your child take medication on a regular basis? If so, please list the medication by name and dosage: **Yes No**

_____

Has your child had surgery? If so, please list the procedure and date: **Yes No**

_____

The above information is complete and correct. If there are any changes during the school year, I understand that it is my responsibility to notify Montessori School of Fort Worth (MSFW). I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize MSFW to contact the above named physician or dentist for treatment.

_____ _____ _____

– Printed Name Parent or Legal Guardian Signature of Parent or Legal Guardian Date

Health Care Provider must complete & sign the medical evaluation and physical examination below

Health Care Professional Please check one.

◯ 1. H EALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is physically able to take part in school program.

_____ _____

Health Care Professional's Signature Date

◯ 2. A signed and dated copy of a health care professional's statement is attached.

Screenings must be after June 1

VISION, HEARING, ACANTHOSIS (required for 4 year olds, 5 year olds, Kinder, 1st, 3rd,5th, and 7th) and All NEW Students ages 4 and above.

Vision	R 20/ _____	L 20/ _____	PASS FAIL
Hearing	**1000 Hz**	**2000 Hz**	**4000 Hz**
R	db	db	db PASS FAIL
L	db	db	db PASS FAIL
Acanthosis nigricans screen			PASS FAIL
Scoliosis Screening	**Females:** Ages 10, 12 or 5th or 7th grade **Males:** Ages 13, 14 or 8th grade		PASS FAIL
SIGNATURE of HEALTH CARE PROVIDER			**DATE**

Please attach a copy of the child's immunization records to this document

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