I.D.E.A.S. Montessori

CHILD'S MEDICAL HISTORY

(To be completed by the Parent)

Name of Child: _____ Age: _____
Surname First Middle

Name of Doctor: _____

Address / Hospital: _____ Phone: _____

Name of Dentist: _____

Address / Hospital: _____ Phone: _____

1. Has the child contracted the following illnesses? (Please check and indicate the year or age the child contracted the illness)

- ☐ Mumps _____
- ☐ Measles _____
- ☐ German Measles _____
- ☐ Chickenpox _____
- ☐ Asthma _____

Has the child ever been treated or diagnosed with any severe or infectious disease that is not listed above? Please describe

_____

_____

2. Has the child received the following immunizations? (Please indicate the date of immunization or include a copy of updated immunization record)

- ☐ Chickenpox _____
- ☐ German Measles _____
- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ MMR Vaccine _____
- ☐ DPT Vaccine _____
- ☐ BCG Injection _____
- ☐ Oral Polio Vaccine _____
- ☐ Flu Vaccine _____
- ☐ CoVid-19 _____

3. Does the child have any hearing difficulty? _____
any vision difficulty? _____
any speech difficulty? _____

4. Is the child able to participate in all physical education activities? ____ Yes ____ No
If not, please describe

_____

5. Does the child have any allergies? Describe allergen, reaction / symptom and treatment plan

_____

_____

6. Does the child require any regular medication? Kindly specify name and instruction in administering the medicine.

_____

_____

7. Please describe any recurring illness or difficulty that may affect or limit the child's participation in a full range of school activities.

_____

_____

8. Has the child undergone any developmental screening? If yes, when and by whom? Kindly attach any related reports or email to admin@ideasmontessori.edu.ph

_____

_____

9. Is there any other medical information you would like to share to help us take better care of the child?

_____

_____

Please attach a medical clearance from your pediatrician if your child has any medical condition that the school should be aware of (e.g. Chronic allergic rhinitis/asthma).

_____ _____

Date Parent's Signature
Over Printed Name