EASTLAKE MONTESSORI SCHOOL
Doctor's Health Record

Child's Name ____

Sex ______ Date of Birth _____________

Name of Parent or Guardian __________________________________

If tuberculin test given: Date _____________ Result ______________

If chest x-rayed: Date _____________ Result ______________

Surgery, accidents, serious illnesses, chronic or handicapping problems:

____

____

Known allergies: ____

Known drug reactions and/or special diets____________________________

Medication currently being taken ______________________________

Does child have any unusual health conditions or limitations? ___________

If yes, please specify: ______________________________________

Comments and instructions for school __________________________

____

Doctor's signature ____________________________ Date: ___________

Doctor's name ____

Doctor's Address

____

Doctor's Phone Number ____________________________

Please also get an immunization record from the doctor's office. Thank you.