Child Medical Report

To be completed by Physician, Physician's Assistant or Nurse.

Montessori Children's Room
67 Old Route 22, Armonk NY 10504
(914) 273-3291, fax (914) 273-3936

Child

Name _____ DOB _____ Date of Exam _____

Immunizations

If one or more of the required immunizations is deemed detrimental to this child's health, attach a certificate specifying which immunization(s) cannot given and why.

DPT	1st / /	2nd / /	3rd / /	Booster / /	Booster / /
Oral Polio	1st / /	2nd / /	3rd / /	Booster / /	Booster / /
HIB	1st / /	2nd / /	3rd / /	4th / /	
Prevnar	1st / /	2nd / /	3rd / /	4th / /	
Hep B	1st / /	2nd / /	3rd / /		
Varicella	1st / /	2nd / /	Has had disease / /		
MMR	1st / /	2nd / /			

Other Immunizations

Type	Date / /
Type	Date / /
Type	Date / /

Tests

Tuberculin Test	Date / /	Test used Tine ☐ Mantoux ☐	Result Pos ☐ Neg ☐	If positive attach physicians statement documenting follow up
Lead Screening / /	Date	If positive attach physicians statement documenting follow up		

Health Specifics

		Comments
Yes ☐ No ☐	Are there allergies?	
Yes ☐ No ☐	Is medication regularly taken? (specify drug & condition)	
Yes ☐ No ☐	Is a special diet needed? (specify diet & condition)	
Yes ☐ No ☐	Are there any communicable diseases?	
Yes ☐ No ☐	Are there any hearing, visual, dental concerns?	
Yes ☐ No ☐	Are there any medical or developmental conditions requiring special attention?	

Summary and recommendations to school.

Signature

Examiner

Name (Print) _____

Address _____

_____ Phone _____

Date ___/___/___ Signature _____

Parent

Name (Print) _____

Signature _____

Date ___/___/___