Montessori Mes Petits Academy
Care & Education

Health History

Name _____ Gender M ☐ F ☐ Date of Birth _____

Place of Birth _____ Care Card No. _____

Home Address _____ Home Tel _____

Father _____Phone/Cell _____ Mother _____Phone/Cell _____
Doctor's Name _____ Doc's Phone _____
Adult living at home with child _____

Vision	Does your child have any vision problems?	Yes ☐	No ☐
Hearing	Has your child had frequent ear infections?	Yes ☐	No ☐
	Does your child have ear tubes?	Yes ☐	No ☐
Speech	Are you concerned about your child's speech or language development?	Yes ☐	No ☐
Other	Indicate any illness, operations, medications or chronic conditions Such as eczema of asthma _____		
Birthmarks	Does your child have any birthmarks or other unusual markings that may be mistaken for an injury? _____		
Allergies	_____		

Please attach a photocopy of your child's immunization record OR fill out the following record

Immunization		dd/mm/yy	dd/mm/yy	dd/mm/yy	dd/mm/yy	dd/mm/yy	dd/mm/yy
Diphtheria							
Pertussis (Whooping Cough)							
Tetanus							
Polio							
Haemophilus Infl. Type B (Hib)							
MMR (Measles,Mumps,Rubella)							
Measles (Rubeola)							
Rubella (German Measles)							
Mumps							
Hepatitis B							
Meningococcal Conjugated							
Pneumococcal Conjugated							
Varicella (Chickenpox)							
List Other Vaccines							

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