

Student Health Form

Parent: Please complete

Student's Name: _____

Birthdate: _____ Sex: _____

Health concerns: None Yes

If yes, please explain below:

Allergies: _____

Chronic Illness: _____

Disability: _____

Other: _____

Parents' or Guardians'
Name, Address, Home Phone

Health Care Provider Contact Information:

Name: _____

Phone: _____

I, _____, give consent for my child's healthcare provider to share the information below and my child's immunization record with Montview Community Preschool and Kindergarten.

Signature of parent or guardian

Date: _____

authorization expires in 365 days

Healthcare Provider:

Please complete after parent section completed

Date of Last Exam: _____

Physical Exam: Normal Abnormal

Significant
Health Concerns: None

Seizures

Allergies

Diabetes

Asthma

Vision

Developmental Delays

Hearing

Hospitalizations

Other (dental, nutrition, behavior)

Medications: None Yes (explain)

Immunizations: Immunization record is attached (mandatory)

Please explain any health concerns:

Signature of Healthcare Provider

This child is healthy and may participate
in all routine activities at school.
Any concerns or exceptions are noted on this form.

Signature of Healthcare Provider

Date

Healthcare Office Stamp

or write name, address, phone# below: