

# 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. I do  / do not  (please initial one) give my permission to have my child's immunization information stored on the State of Colorado Immunization Information System (CIIS), an online database.

\_\_\_\_\_  
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.

Healthcare Office Stamp

or write name, address, phone# below:

\_\_\_\_\_  
Signature of Healthcare Provider

\_\_\_\_\_  
Date