



MEDICAL HISTORY FORM

Full name of student _____

Health insurance No. of the child _____

Name of Family Physician _____

Address _____ Tel. : _____

CONTAGIOUS DISEASES :

Measles _____ German measles _____ Scarlet Fever _____

Chicken pox _____ Mumps _____ Mononucleosis _____ Others _____

Has the child had any operations or accidents _____

Your estimation of the child's general health? _____

Does the child have any physical defects? _____

Your estimation of the child's general growth and development _____

Is the child prone to upper respiratory infections? _____

Does the child have any medical condition or psychological problems resulting in behaviour problems: _____

Is the child receiving treatment? _____ Why? _____

Does the child have any allergies? _____

IMMUNIZATIONS AGAINST:

Diphtheria (D) – Tetanus (T) – Pertussis (aP) yes _____ Date of last booster _____

- Poliomyelitis (Salk) – Haemophilus influenza type b (Hib) :

Measles (M) – Mumps (M) – Rubella(R) yes _____ Date of last booster _____

- Chickenpox (Va) :

Meningococcal infection (MENJ) : yes _____ Date of last booster _____

Hepatitis A (HA) – Hepatitis B : yes _____ Date of last booster _____

Tuberculosis (BCG) : yes _____ Date of last booster _____

Pneumococcal infection (PREVNAR) : yes _____ Date of last booster _____

Cholera – Typhoid – Japanese encephalitis : yes _____ Date of last booster _____

Other vaccines : yes _____ Date of last booster _____

General comments : _____

In case of an emergency, we hereby give the authority to ÉCOLE MONTESSORI VILLE-MARIE to have our child attended medically by a physician or a hospital.

Parents' Signature _____ Date : _____