Peace Montessori
2011-2012 MEDICAL FORM
Fax: 260.493.9089

To be completed by parent:

Child's name: _____ Birth Date: _____

Address: _____City:_____

State: _____ Zip: _____ Phone: _____

Parent Signature: _____Date_____

To be completed by Physician:
Please complete dates of completed immunizations and fax back to the number listed above

DTAP:	**Polio Shot** (please specify):	**Hep B Series:**	**HIB:**
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5			

Varicella:	**MMR:**
1	1
2	2

Does the child have any record of serious illness, injury or surgery? _____

Does the child have any allergies or dietary restrictions? Please list. _____

In your opinion, is the child able to participate fully in school activities? _____

Please list any medication(s) the child is currently taking. _____

Other comments:

_____
Physician's signature

(Revised 6-11)