Casa di Mir Montessori School
Health Information Record

Name_____ ❒ M ❒ F
LAST FIRST MIDDLE

Address _____ Date of Birth_____
CITY STATE ZIP

Parent or Guardian_____Home Phone _____

Doctor_____
NAME PHONE

Dentist_____
NAME PHONE

MEDICAL CONDITIONS	**YES**	**NO**	**PLEASE EXPLAIN (use back if necessary)**
Allergies: - Food	☐	☐	*If yes, please answer questions in the box on the reverse side of this form.*
- Bees	☐	☐	*If yes, please answer questions in the box on the reverse side of this form.*
Asthma:	☐	☐	*Specify treatment required (e.g., inhaler):*
Diabetes:	☐	☐	
Epilepsy:	☐	☐	
Convulsions:	☐	☐	
Headaches/Migraines	☐	☐	
Fainting Spells:	☐	☐	
Eczema/Psoriasis:	☐	☐	
Nosebleeds:	☐	☐	
Sleep Disorders	☐	☐	
Environmental Sensitivities:	☐	☐	
Emergency Medication Needed:	☐	☐	
Vision Problems:	☐	☐	
Wears Glasses	☐	☐	
Wears Contact Lenses	☐	☐	
Hearing Difficulty:	☐	☐	
Wears Hearing Aid	☐	☐	
Prescription Medications:	☐	☐	
Physical Defect:Heart Disorder, etc	☐	☐	
Limited Physical Activities	☐	☐	
Other:			
			Please turn over and complete reverse side.

☐ My child has the following allergic reactions: _____

☐ My child needs no special treatment for his/her allergic reaction.

☐ My child requires immediate treatment for allergic reactions, specified as follows:

_____

(Note: Parents must provide epipen or inhaler, if needed, along with physician's note.)

Please note that Casa di Mir Montessori is <u>not</u> a nut-free school.

I declare that the health information listed on this form is accurate and complete.

_____ _____

Parent signature *Date*