Creative Montessori School and Daycare
Health Inventory

To be completed by parent or guardian. Please check all that apply

Student Name: ____Date of Birth: _____________________

ALLERGIES:
Needs medication at school and/or medical follow-up
Bee/Insect
reaction ________________________
treatment _______________________
Food allergy (list foods) ________________
____
____
reaction ________________________
treatment _______________________
Other allergy ________________________
reaction ________________________
treatment _______________________

ASTHMA:
Needs medication at school
type ________________________________
how often? ___________________________
Has asthma, but no medication is needed at school

ATTENTION DEFICIT DISORDER (ADD / ADHD):
Needs medication at school
type ________________________________
how often? ___________________________
Takes medication at home only
Diagnosed, but not taking medication

HEARING / VISION CONCERNS:
Wears hearing aid in:
left____ right____ both____ ears
Diagnosed hearing loss in:
left____ right____ both____ ears
Wears glasses
Colorblind
Blind in:
left____ right ____both ____eyes

PHYSICAL RESTRICTIONS:
Restricted because of
____
(requires a physician's note)

SEIZURES:
Needs medication at school
type ___________________________
how often? ______________________

Takes medication at home only
History of seizures, but not presently medicated
History of febrile seizures

DIABETES:
Insulin dependent

AUTISM: Has your child been evaluated and/or diagnosed with Autism? Yes No
If yes, explain____

Does your child have an ADA (American's with Disabilities Act) diagnosis? Yes No
If yes, explain____

BEHAVIOR CONCERNS:
____

Other health concerns that would affect school performance:
____

NOTE: If student needs prescription medication administered at school, a parent and doctor must complete a health care plan form before the first dose of medication can be administered by any school personnel.

Over the counter medications may be distributed with a parental authorization only. (Form required)

The information contained on this form may be shared with school personnel as necessary to care for your child. **Please keep this information up to date.**

_________________________ _________________________ _________________________

Creative Montessori School and Daycare
Health Inventory

Printed Name of Parent or Guardian   Signature of Parent or Guardian   Date

Home Phone ___________________   Work Phone ____________________   Cell Phone______________________