Montessori Science Academy

5684 W. US 52,
New Palestine, IN 46163

MEDICAL PROFILE

CHILD'S NAME

First Name	M. I	Last Name	Date of Birth:Day / Month / Year

Name of Child Family Physician		
Physician's address: Street No.	City	Postal Code
Physician's Phone No		

Previous History of Communicable Diseases

1	
2	

ALLERGIES

Does your child suffer from any allergies ?	Yes ☐	No ☐
If yes, Please give details of foods or items suspected of causing the allergy		
Is your child receiving or to be provided any medication for the allergy.		

GENERAL

HAS YOUR CHILD EVER HAD HIS/HER EYES TESTED ?	Yes ☐	No ☐	Result
HAS YOUR CHILD EVER HAD HIS/HER HEARING TESTED ?	Yes ☐	No ☐	Result
IS YOUR CHILD CURRENTLY RECEIVING ANY MEDICAL TREATMENT ?	Yes ☐	No ☐	
IF YES STATE DETAILS AND MEDICATION:			
ANY OTHER MEDICAL CONCERNS OR DETAILS YOU WISH TO PROVIDE			

SPECIAL REQUIREMENTS : PLEASE PROVIDE INSTRUCTIONS, IF ANY, ABOUT ANY SPECIAL REQUIREMENTS FOR YOUR CHILD'S DIET, REST OR EXERCISE:

IMMUNIZATION RECORD : PLEASE PROVIDE A PHOTOCOPY OF IMMUNIZATION CARD

Parent's Signature_____ **Date**_____