

ALCOTT SCHOOL

Name of child: _____ Date: _____

Note: The following supplemental information will provide a better understanding of any medical concerns this child may have.

MEDICAL HISTORY

(Please indicate dates if child has had these illnesses)

	No	Yes	Dates
Seizures			
Heart Condition			
Otitis Media/Serous Otitis			
Asthma/RAD			

Hospitalizations, Injuries, Fractures (please give hospital & dates):

Surgical Procedures:

Medical Referrals: (ENT, Neurologist, etc.):

If child is taking medication, please indicate:

Name of Medication

Dosage and Frequency

a. _____

b. _____

c. _____

Should child have any emergency medication in school? _____

If yes, please state name of Medication and Dosage _____

Please state any concerns with cognitive, speech or motor development: _____

****IMPORTANT*** Please note that children in need of Occupational, Physical or Speech Therapies are evaluated by appropriate specialists. Based on these recommendations, a prescription for services is made in conjunction with Alcott's nurse practitioner.

PLEASE INDICATE ANY CONTRAINDICATIONS TO THERAPY: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Percentile _____ B.M.I. _____

Blood Pressure: _____ Pulse: _____