



ALBANY MONTESSORI SCHOOL MEDICAL RECORD

Personal Details:

Child's Name:

Date of Birth:

Address:

Home Tel:

Mother's Business No.

Father's Business No:

Emergency Contact - Name, address and telephone number:

Family Doctor/ Health Visitor - Name, address and telephone number:

Vaccination record and dates:

MMR:

Polio:

Meningitis C:

Tetanus:

Diphtheria:

Other:

Medical History:

Does your child suffer from allergies?

Does your child suffer from respiratory problems?

Does your child wear glasses or suffer from hearing or speech problems?

Please state any other illness/surgery:

Please complete the following with dates if your child has had:

Chicken Pox:

Meningitis:

Scarlet Fever:

Heart Disease:

Rubella:

Measles:

Tuberculosis:

Infectious Hepatitis:

Poliomyelitis:

Whooping Cough:

Diphtheria:

Rheumatic Fever:

Mumps:

Pneumonia:

Diabetes:

Convulsions:

Haemophilia:

Other:

Does the child take medication regularly?

Please state any other information that you feel the school should know in the interest of your child:

Please List Dietary Allergies/Intolerance's/Requirements:

Does your child have any Special Educational Needs?

We consent to our child being given emergency medical treatment if required. We hereby give permission for our child to participate in cooking, lunch and party activities and accept that this will involve our child eating food at school and have informed the school of any allergies/intolerance's. We agree to keep the school informed and up to date of any changes or developments with regard to allergies/intolerance's.

Signature of Mother:

Date:

Signature of Father:

Date: