Village Montessori School

General Health Information Form/Record of Immunization

I. GENERAL HEALTH INFORMATION FORM, to be completed by guardian

Student's Name: _____ DOB: _____/_____/_____ Gender: _____

Mother or Legal Guardian: _____ Phone: _____ Alternate: _____

Father or Legal Guardian: _____ Phone: _____ Alternate: _____

Emergency Contact: _____ Phone: _____ Alternate: _____

Physician: _____ Address and Phone: _____

If you need additional space, please use the back of this form.

Condition	Yes	Comments	Condition	Yes	Comments
ADHD			Diabetes		
Allergies (food, insects, drugs, latex)			Head injury, concussions		
Allergies (seasonal)			Hearing problems or deafness		
Asthma or breathing problems			Heart problems		
Behavioral problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Spinal injury		
Dental problems			Surgery		
Developmental problems			Vision problems		

Authorization for Emergency Medical Care: By signing, I give consent for Village Montessori School to authorize any and all medical and/or dental attention to be administered to my child in the event of an emergency should his/her parents be unreachable. This permission includes, but is not limited to, the use of an ambulance, the administration of first aid, anesthesia, and/or surgery, under the recommendation of qualified medical personnel. I further authorize Village Montessori School to use Tylenol if my child has a fever and his/her parents cannot be reached.

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Signature

Part II – Immunization Record, to be completed by physician or his designee, registered nurse, or health department official

State law (Ref. Ark. Code Ann. §§ 20-7-109, 6-18-702, 6-60-501 - 504, and 20-78-206) requires that your child is immunized before attending school in Arkansas. A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form, as is an Exemption Form granted by the Arkansas Department of Health.

Form must be signed and dated in the appropriate box.

Student's Name: _____ Date of Birth: _____

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN			
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**
Polio (IPV, OPV)	**1**	**2**	**3**	**4**
HIB (HBCV) **only for children <5 years of age*	**1**	**2**	**3**	**4**
Pneumococcal (PCV conjugate) **only for children <5 years of age*	**1**	**2**	**3**	**4**
Measles, Mumps, Rubella (MMR)	**1**	2		
Hepatitis B (HBV)	**1**	**2**	**3**	
Varicella (Chicken Pox)	**1**	**2**		

I certify that this child is **ADEQUATELY OR AGE-APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State of Arkansas.

Signature of Medical Provider or Health Department Official: _____

Date: _____