MISD
THE MONTESSORI INSTITUTE OF SAN DIEGO

Student Name: _____ Date:_____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has?

_____ ADD/ADHD
_____ Learning disability
_____Physical disability
_____Fainting spells
_____ Asthma
_____ Diabetes
_____ Heart condition
_____Other_____

Does your child experience any of the following?

_____ Seizure disorder
_____ Bleeding disorder
_____ Bone/muscle disease
_____ Skin condition
_____ Mental health condition (i.e., depression, anxiety, eating disorder)
_____Frequent ear aches
_____Frequent stomach aches
_____Frequent headaches
_____Overweight for age
_____Underweight for age
_____ Nose bleeds
_____ Poor appetite
_____ Tires easily
_____Emotional concerns

Do any of the above condition(s) limit/effect your child at school?

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? **Yes/ No**
If yes, please attach a description provided by your physician when submitting this form.

ALLERGIES

Does your child have any allergies? **Yes/ No**
Plants _____ Animals _____ Food _____ Molds _____ Drugs _____ Bees _____ Other_____
If yes, please attach the allergic reaction and the treatment plan as prescribed by your physician for each checked allergy.

MEDICATION

Does your child take any medication? **Yes/ No**
If yes, does this medication need to be administered at school: **Yes/ No**
If yes, please attach a description provided by your physician when submitting this form.

HEARING/VISION

Do you have concerns about your child's hearing? **Yes/ No**
Does your child wear hearing aides? **Yes/ No**
Do you have concerns about your child's vision? **Yes/ No**
Does your child wear glasses or contacts? **Yes/ No**