ALCOTT SCHOOL

Name of child:_____ **Date:**_____

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. _____ _____

State any emergency medication needed while in school _____

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: _____

Recommended			Check if Untestable	Referral
Vision-without glasses	R	L		
Vision-with glasses	R	L		
Vision-near point	R	L		
Color Vision	P	F		
Hearing-❒ Check if Pass– 20db both ears or	R	L		