



195, Av. De Tervuren 1150 Brussels | Tel. : 02/733.63.55  
info@montessoribrussels.org

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## Child's Medical History

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

### **RECORD OF VACCINATIONS / DISEASES**

Please record whether or not your child has had the following illnesses, along with the dates of any vaccinations, where appropriate.

<b>ILLNESS</b>	<b>DATE(S) OF VACCINATIONS</b>	<b>DATE(S) OF ILLNESS, IF APPLICABLE</b>
<b>DIPHTHERIA</b>		
<b>WHOOPING COUGH</b>		
<b>TETANUS</b>		
<b>POLIO</b>		
<b>MEASLES</b>		
<b>MUMPS</b>		
<b>RUBELLA / GERMAN MEASLES</b>		
<b>BCG (FOR TUBERCULOSIS)</b>		

## UNUSUAL ILLNESSES

Please list any unusual medical problems, excluding common illnesses:

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## ALLERGIES

Does your child have any allergies? Please include any allergies to medication:

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## EAR, NOSE & THROAT PROBLEMS

Please list any unusual problems your child has had in hearing, ear infections, breathing (Asthma), throat etc...

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## OTHER RELEVANT MEDICAL INFORMATION

Is the child using any medication? Has he/she ever been in hospital?

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## DETAILS OF FAMILY DOCTOR

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Telephone No.: \_\_\_\_\_

## EMERGENCY CONTACTS

Who should we contact in case of emergency? Please give two names and telephone numbers.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**I / We hereby certify that the information given above is true and correct in all particulars.**

**I / We authorize Montessori House Brussels to provide medical treatment in case of emergency.**

**ADDRESS :**

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**SIGNATURE OF  
PARENT/GUARDIAN :**

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**DATE :**

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