MONTESSORI HOUSE BRUSSELS

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info@montessoribrussels.org

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.

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

UNUSUAL ILLNESSES

Excluding common illnesses. Please list any unusual medical problems:

ALLERGIES

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

EAR, NOSE & THROAT PROBLEMS

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

OTHER RELEVANT MEDICAL INFORMATION

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

Is the child following any therapy (ergo, occupational, speech ….)?:

DETAILS OF FAMILY DOCTOR

Name: _____

Address: _____

_____

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.

ADDRESS :

SIGNATURE OF PARENT/GUARDIAN :

DATE :
