

RUFFING MONTESSORI SCHOOL
3380 Fairmount Boulevard - Cleveland Heights, OH 44118
216.321.7571

HEALTH HISTORY
(To be completed by parent)

Name _____ Phone _____

Grade _____

Allergies - List and describe reactions:

Insect stings _____

Food/plants/animals _____

Medications _____

Recommended treatment _____

Asthma _____ Treatment required _____

Bone/joint disorder _____

Blood disorders _____

Cancer _____ Explain _____

Chicken pox _____ Date _____

Convulsions/Seizures _____ Frequency _____ Medication _____

Diabetes _____ Age of onset _____ Treatment _____

Ear infections _____ Frequency _____ Age of last infection _____ Tubes? _____

Hearing problems _____ Hearing aids - yes _____ no _____

Heart disease _____ Describe _____

Kidney disease _____ Describe _____

Nervous system disorder _____

Skin disorder _____ Describe _____

Speech difficulty _____ Describe _____

Stomach/intestinal disorders _____ Describe _____

Strep infections _____ Frequency _____ Date of last infection _____

Scarlet fever _____ Date _____ Rheumatic fever _____ Date _____

Vision problems _____ Describe _____

Treatment _____ Glasses: Yes _____ Near/Far No _____

Other physical disabilities: Describe _____

Parent/Guardian Signature _____ Date _____

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SCHOOL ENTRANCE PHYSICAL EXAMINATION
(To be completed and signed by physician)

Name _____

Birthdate _____ Height _____ Weight _____ Blood Pressure _____

General appearance _____

Nutritional status _____

	Normal/Abnormal		Normal/Abnormal
Posture	_____	Neck	_____
Skin	_____	Heart	_____
Eyes	_____	Lungs	_____
Ears	_____	Abdomen	_____
Nose	_____	Genitalia	_____
Throat	_____	Hernia	_____
Mouth	_____	Nervous system	_____
Musculoskeletal	_____	Other (specify)	_____

Remarks and recommendations concerning abnormal findings _____

Medications: Name of medication _____ Dosage _____

Frequency _____ Reason for medication _____

Was child referred to a specialist for any reason? Explain _____

Immunization Information

DPT 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
Mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

Polio 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
Mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

MMR 1 _____ 2 _____ Chicken pox 1 _____ 2 _____
Mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

HIB 1 _____ 2 _____ 3 _____ 4 _____
Mo/day/year mo/day/year mo/day/year mo/day/year

Hepatitis B 1 _____ 2 _____ 3 _____ Hepatitis A 1 _____ 2 _____
Mo/day/yr mo/day/yr mo/day/yr mo/day/yr mo/day/yr

Tuberculin test: (most recent) Date _____ Type _____ Results: Pos. _____ Neg. _____

Physician's Signature _____ Date _____

