



Medical Form

Patient Information

Students Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Pediatrician Contact Information: \_\_\_\_\_

Child's Medical Form

Dear Pediatrician/Physician/Health Care Professional:

Montessori Escuela, by request of The Department of Early Education and Care, requires that all children/students who will be in a small group, home-based Montessori school child care program with other children, be examined by a pediatrician physician/health care professional within one year of admission into the program. The department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid one (1) year from the date the child was examined and must be renewed annually thereafter.

Your patient, (enter child's name) \_\_\_\_\_, is required to submit this medical form as part of his/her school enrollment requirement. Please fill out the form in its entirety and return it to your patient.

Name of patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Name of Parents: \_\_\_\_\_

In your professional opinion concerning the child's general health and appearance?

\_\_\_\_\_  
\_\_\_\_\_

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care educator? If so, please detail below:

\_\_\_\_\_  
\_\_\_\_\_

In your professional opinion does your patient have any limitations that would affect his/her ability to interact with other young children? If yes, please provide details of any of these limitations.

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Comments: \_\_\_\_\_  
\_\_\_\_\_

Please answer the following questions:

1. Has this child been immunized in accordance with the requirements of the Department of Public Health recommendation schedule (Mumps, Measles and Rubella)?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
2. Has this child had a complete physical examination within the past year?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
3. Has this child been screened for lead poisoning? (Pursuant to the department of Public Health requirements, all children, regardless of risk, must be screened for lead poisoning at least one (1) time between the ages of nine and twelve months, annually thereafter at the ages of two and three, and at age four if at high risk for lead poisoning)  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, dates screened: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician/Health Care Professional

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
License Number

Please return this form and the child's immunization record to:

**Montessori Escuela**  
**34 Ridge Road**  
**Belmont, MA 02478**