UNITARIAN MONTESSORI SCHOOL
WHERE CHILDREN COME FIRST
UMS

HEALTH HISTORY

Student's Full Name: _____

Male { } Female { } Date of Birth: _____

Parent/Guardian: _____ Contact Phone: _____

MEDICAL

Name of Doctor: _____ Phone: _____

Name & Address of Medical Facility: _____

DENTAL (if none, please write none)

Name of child's dentist: _____ Phone: _____

HEARING/VISION

Does your child have hearing loss? Yes ___ No ___ Are hearing aides required? Yes ___ No ___ Does your child have vision loss? Yes ___ No ___ Are glasses required? Yes ___ No ___

Remarks _____

SPEECH/LANGUAGE

Is English your primary language? Yes ___ No ___ If not, what is? _____

Do others have difficulty understanding your child? Yes ___ No ___

Remarks _____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___ Asthma___ Diabetes___ Heart condition ___ Bleeding disorder ___ ADD/ADHD ___ Bone/muscle disease ___ Skin condition ___ Mental health condition ___ Learning disability ___ Seizure disorder
Other
_____
__

Does your child experience any of the following?

___ Nose bleeds ___ Poor appetite ___ Tires easily ___ Frequent ear aches
___ Frequent stomach aches ___ Emotional concerns ___ Frequent headaches

Other
_____
__ Do any of the above condition(s) limit/effect your child at school? Yes __ No __

ALLERGIES

___ Plants ___ Animals ___ Food * (see below) ___ Molds ___ Drugs ___ Bees

Other
_____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes ___ No ___

Describe:
_____

MEDICATION

Does your child take any medications? Yes ___ No ___ If yes, name medication _____ Purpose: _____ Will medication be needed at school? Yes __ No __

*FOOD ALLERGY ASSESSMENT FORM

Doctor treating food allergy: _____ Phone: _____ Facility: _____ Do you think your child's food allergy may be life-threatening? Yes __ No __
Did your child's doctor tell you the food allergy may be life-threatening? Yes __ No __
Has your child's doctor required an allergy free environment at home Yes __ No __ and/or in the classroom? Yes __ No __ If your doctor is requiring an allergy free classroom, his/her letter must be attached.

If your child has a life-threatening food allergy, parents must provide snack for their children to keep in their classroom.

HISTORY and CURRENT STATUS

Check the foods that have caused an allergic reaction:
___ Peanuts/Peanut butter/Peanut oil ___ Tree Nuts (walnuts, almonds, pecans, etc.)
___ Fish/shellfish ___ Eggs ___ Milk/dairy ___ Soy products
Please list any others:
_____

How many times has your student had a reaction? Never ___ Once ___ More than once ____
Explain:
_____
When was the last reaction? _____
Are the food allergy reactions: Staying the same ____ Getting worse ___ Getting better ___

TRIGGERS AND SYMPTOMS

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*
___ Eating foods ___ Touching foods ___ Smelling foods ___ Other, please explain:
_____ Is it possible for other classroom students to have the identified products in their lunch/snack as long as they sit at a different table? Yes ___ No ___ (If No, a letter from your doctor must be attached.)
What are the signs and symptoms of your child's allergic reaction? *(Be specific; include things the student might say.)*

_____
How quickly do the signs and symptoms appear after exposure to the food(s)?
Seconds ___ Minutes ___ Hours ___ Days ___

TREATMENT

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?
Yes ___ No ___ Explain:
_____ Does your child understand how to avoid foods that cause allergic reactions? Yes ___ No ___
What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

_____

_____

Have you used the treatment? Yes ___ No ___
Describe any side effects or problems your child had in using the suggested treatment:
_____

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

☐ PARENT/GUARDIAN # 1		☐ PARENT/GUARDIAN # 2	
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:	
Home Address:		Home Address :	
Employer Name:		Employer Name:	
Employer Phone:		Employer Phone:	
E-Mail Address:		E-Mail Address:	

EMERGENCY CONTACTS

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

Contact Name #1:		Contact Name #2:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer Phone:		Employer Phone:		Employer Phone:	

CUSTODY

Name of person PROHIBITED from picking up your child:	

If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.

MEDICAL INFORMATION

Child's Health Care Provider:	
Health Care Provider Phone:	
Health Care Provider Address:	
Name Of Insurance Company/Hmo:	
Group #:	
Identification #:	
Subscriber's Name On Insurance Card:	
Known Allergies (including medication):	
Medication My Child Is Taking:	
List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:	

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date:

Media Release and Class Pets

There may be times when pictures, video and student's work will be posted on the Unitarian Montessori School's website and on the school blog, Bloomz or Facebook/Twitter. This media release form will serve as a permission to post such information as needed.

Media Release Form

I hereby give permission to the school to photograph my child. It is my understanding that this photograph will be used in the public domain.

I agree to participate in these projects without financial remuneration, and I understand that this releases the school from any future claims, as well as from my liability, arising from the use of the said photographs or videos.

Classroom Pets

I hereby give permission to the school to have classroom pets. It is my understanding that a rabbit, a bird, a hamster and fish/frogs in the aquarium may be the classroom pet.

Name of Child: _____

(Please print or type)

Address: _____

City, State, Zip: _____

Signature of parent or guardian: _____

Date: _____

Permission to Apply
Insect Repellent and/or Sun Screen to Child

Center Name:			
Child's Name:		Child's Age:	

As the parent/guardian of the above named child, I have initialed next to the applicable statement(s) for the use of ***insect repellent*** on my child:

_____ Staff may apply the center's ***insect repellent*** according to the directions on the product label.

_____ I do not know of any allergies my child has to children's ***insect repellent***.

_____ ~~My child is allergic to some ***insect repellents***~~. I have provided the following brand/type of ***insect repellent*** for use on my child:

_____

_____ Please DO NOT apply ***insect repellent*** to the following areas of my child's body:

_____

Please do not apply insect repellent to my child.

Parent/Guardian's Name:	Parent/Guardian's Signature:	Date:

As the parent/guardian of the above named child, I have initialed next to the applicable statement(s) for the use of ***sun screen*** on my child:

_____ Staff may use the center's ***sun screen*** according to the directions on the product label.

_____ I do not know of any allergies my child has to children's sun screen.

_____ ~~My child is allergic to some ***sun screens***.~~ I have provided the following brand/type of ***sun screen*** for use on my child:

_____

_____ Please DO NOT apply ***sun screen*** to the following areas of my child's body:

_____

_____ **Please do not apply sun screen to my child.**

Parent/Guardian's Name:	Parent/Guardian's Signature:	Date:

PARENT
RECEIPT OF INFORMATION:

- ☐ Information to Parents Document
- ☐ Policy on the Release of Children
- ☐ Policy on Methods of Parental Notification
  (Applicable only if a method other than a phone call is used to notify parents of an injury to a child's head, a bite that breaks the skin, a fall from a height, or an injury requiring professional medical attention.)
- ☐ Policy on Communicable Disease Management
- ☐ Expulsion Policy
- ☐ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.

Child(ren)'s Name: _____

Parent/Guardian's Name: _____

_____ _____
Signature Date

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	