Portage Collaborative Montessori School
MEDICAL STATEMENT

Child's Last Name First	Birth Date	Age
Address	Phone	
Parent/Guardian	School	

Parental Consent for release of this medical statement

I, the legal guardian, authorize the release of this medical statement to Portage Montessori School.

X_____ _____

Signature of Parent or Guardian Date signed

Immunizations: Please include month, day, and year. ***** Indicates required for pre-school.

DPT #1*_____ #2*_____ #3*_____ #4*_____ #5_____

OPV/IPV #1*_____ OPV/IPV #2*_____ OPV/IPV #3*_____ OPV/IPV #4 _____

(Circle type of polio given)

MMR #1*_____ #2_____ VZV #1 _____ VZV #2 _____

HIB #1*_____ #2 _____ #3_____ #4_____

Only one HIB required if given after 15 months of age. Please indicate if 4th HIB is not required.

HEP B #1*_____ #2*_____ #3*_____ Other_____

TB last given _____Sickle Cell_____Lead_____

Physical Assessment: WNL_____ Yes_____ No_____	
Please note if any follow up is required	
Height_____ Blood Pressure_____	
Weight_____ Hematocrit or Hemoglobin_____	
Allergies/Include Food NKA: Yes_____No_____Treatment:_____	
Screenings: WNL Follow up required	
Vision (Beginning at age 3)	
Hearing (Beginning at age 3)	
Speech	

THIS STATEMENT AFFIRMS THAT THE ABOVE NAMED CHILD IS IN SUITABLE CONDITION FOR ENROLLMENT IN A PRESCHOOL/KINDERGARTEN PROGRAM.

Physician's Signature_____Date_____

Physician's Name (please print)_____

Physician's Address_____

City, State, Zip_____Phone_____

**Parents must fill in top portion.