



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_

Address: \_\_\_\_\_ Home Ph#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parents or guardian: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Work: Mother \_\_\_\_\_ Phone \_\_\_\_\_

Work: Father \_\_\_\_\_ Phone \_\_\_\_\_

Cell Phone and/or pager number: Mother \_\_\_\_\_ / \_\_\_\_\_

Cell Phone and/or pager number: Father \_\_\_\_\_ / \_\_\_\_\_

Date of Admission \_\_\_\_\_

Persons to call in emergency (if parents unavailable):

Name: \_\_\_\_\_ Ph #: \_\_\_\_\_ Relationship: \_\_\_\_\_

I hereby authorize Kingwood Montessori to allow my child to leave the premises ONLY with the following persons:

\_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, or injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of:

No \_\_\_\_\_ Yes, (List) \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:**

In the event that I cannot be reached for immediate emergency medical attention, I authorize the Kingwood Montessori to take my child to the nearest hospital emergency room or clinic. My child's attending physician is:

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby give my consent for necessary emergency treatment when my child is in the care of this physician and/or the nearest hospital or clinic.

\_\_\_\_\_

**Signature - Parent or Legal Guardian**

**WATER ACTIVITIES:** I hereby  give  do not give my consent for my child to participate in water activities.

Splashing Pools  Wading pool  Swimming pools  Other bodies of water provided by the facility

**TRANSPORTATION:** I hereby  give  do not give my consent for my child to be transported and supervised by facility staff or parent volunteers on field trips.

Date: \_\_\_\_\_

\_\_\_\_\_

**Signature - Parent or Legal Guardian**

Child's Name:

Date of Birth:

Vaccine	MONTHS								YEARS		
	Birth	1	2	4	6	12	15	18	4-6	11-12	14-16
<b>Hepatitis B</b>											
<b>Hepatitis A</b>											
<b>DTaP/DTP</b> Diphtheria, Tetanus, Pertussis											
<b>Haemophilus</b> Haemophilus influenzae type B											
<b>Pneumococcal Conjugate</b>											
<b>Polio</b> IPV or OPV											
<b>MMR</b> Measles, Mumps, Rubella											
<b>Varicella</b> Chicken Pox											

This is to verify that \_\_\_\_\_ had varicella disease (chicken pox) on or about \_\_\_\_\_ (date) and does not need the varicella vaccine.  
Date \_\_\_\_\_

Parent's Signature or Physician

<b>T.B. Test (if Required)</b>	<b>( ) Positive</b>	<b>( ) Negative</b>	<b>Date:</b>	
--------------------------------	---------------------	---------------------	--------------	--

- Admission requirements for **FIRST TIME STUDENTS ONLY**: Your health care physician must complete the Doctor's Statement below. If you are unable to obtain a physicians signature within 10 days from the start of school please sign the following **Parent Statement**.

*My child has been examined within the last year and is able to participate in the school program. I have a doctor's appointment on \_\_\_\_\_ after which time I will provide the school with the required Doctor's statement.*

Parent's Signature

<ul style="list-style-type: none"> <li>This is to certify _____ has been examined by me and found to be free of contagious diseases and that the immunization information provided is accurate.</li> </ul> <p>Date _____</p> <p>Signature of Physician _____</p> <p>Address: _____ City: _____ Zip: _____</p>
---

- \*\*Serologic proof of immunity to Measles/Rubella/Mumps/Hepatitis A/Hepatitis B illness. This is to verify that \_\_\_\_\_ has serologic proof of (circle one) measles, rubella, mumps, hepatitis A, or hepatitis B illness.

Date

Signature of Physician

**Vision and Hearing Requirements**

All students at the Kingwood Montessori, 4 years and older and all Kindergarten, 1<sup>st</sup> 3<sup>rd</sup>, and 5<sup>th</sup> graders are required to have vision and hearing screening.

Hearing Screening

At 25 db	R	L
500 Hz	_____	_____
1000 Hz	_____	_____
2000 Hz	_____	_____
4000 Hz	_____	_____

Vision Screening:

Distance Acuity: R-20/ \_\_\_\_\_ L-20 \_\_\_\_\_

\_\_\_\_\_ Pass \_\_\_\_\_ Fail

Signature & Date