



Name: \_\_\_\_\_  
Last Name First Name Middle Name

DOB: \_\_\_\_\_ Gender: M F Grade: \_\_\_\_\_

*The required components are identified with an asterisk (\*).*

How frequently do you see this child when he/she is not ill? \_\_\_\_\_

How long have you been seeing this child? \_\_\_\_\_

Allergies: \_\_\_\_\_

Modified Diet: \_\_\_\_\_

Routine Medications: \_\_\_\_\_

(Sunny Hollow Montessori requires Medical Authorization Form for all routine and emergency medication)

\*Height: \_\_\_\_\_ ins. \*Weight: \_\_\_\_\_ lbs. Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

Corrected: Yes No

Hearing Status: \_\_\_\_\_

Hearing Aid: Yes No

	500 (25)	1000 (20)	2000 (20)	4000 (20)
Right				
Left				

Test	Date	Results
Hemoglobin		
Urinalysis		
Tuberculin (PPD)		
Chest x-ray		
Blood lead level		

### \* Developmental Screening

Approved Screening Tool	Screening Tool Used	Results/Comments
Direct observation using a standardized instrument approved by MN Department of Education (MDE): <b>1. Parent Report Instruments:</b> <ul style="list-style-type: none"> <li>Ages &amp; Stages Questionnaire (ASQ)</li> <li>Child Development Review Parent Questionnaire (CDR-PQ)</li> <li>Infant Development Inventory (IDI)</li> <li>Parents' Evaluation of Development Status (PEDS)</li> </ul> <b>2. Observational Instruments:</b> <ul style="list-style-type: none"> <li>Brigance Screens</li> <li>Developmental Indicators for Assessment of Learning - 3<sup>rd</sup> Ed. (DIAL-3)</li> <li>Early Screening Inventory - Revised (ESI-R)</li> <li>Early Screening Profiles</li> <li>FirstSTEP Preschool Screening Tool</li> <li>Minneapolis Preschool Screening Instrument - Revised (MPSI-R)</li> </ul> <b>3. Social/Emotional Screening Instruments:</b> <ul style="list-style-type: none"> <li>Ages &amp; Stages Questionnaire: Social - Emotional (ASQ:SE)</li> <li>Brief Infant Toddler Social Emotional Assessment (BITSEA)</li> <li>Pediatric Symptom Checklist (PSC)</li> </ul>		

## HEALTH SUMMARY

\* Normal \* Abnormal

Eyes		
cover test		
corneal reflection		
Ears		
Mouth – teeth		
Throat		
Nose		
Lymph nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Hernia		
Genitourinary		
Tanner I II III IV V		
Musculoskeletal		
Spine		
Extremities		
Feet		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Speech		
Physical Education Restrictions:		

\* There is a condition that may result in an emergency: Yes No (if yes, elaborate below)

\* There is a condition that may interfere with learning: Yes No (if yes, elaborate below)

\*Please elaborate on any abnormal findings or chronic conditions:

Note: A separate form is required for all medication and treatment orders.

Problem	Assessment	Plan

Signature of Health Care Provider (HCP)

Print Name

Date of Physical

Clinic Name

Phone

Current Date

