Name: _____
Last Name *First Name* *Middle Name*

DOB: _____ Gender: M F Grade: _____

Sunny Hollow MONTESSORI

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				

	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): **1. Parent Report Instruments:** • Ages & Stages Questionnaire (ASQ) • Child Development Review Parent Questionnaire (CDR-PQ) • Infant Development Inventory (IDI) • Parents' Evaluation of Development Status (PEDS) **2. Observational Instruments:** • Brigance Screens • Developmental Indicators for Assessment of Learning - 3rd Ed. (DIAL-3) • Early Screening Inventory - Revised (ESI-R) • Early Screening Profiles • FirstSTEP Preschool Screening Tool • Minneapolis Preschool Screening Instrument - Revised (MPSI-R) **3. Social/Emotional Screening Instruments:** • Ages & Stages Questionnaire: Social - Emotional (ASQ:SE) • Brief Infant Toddler Social Emotional Assessment (BITSEA) • Pediactric Symptom Checklist (PSC)		

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*