Free Horizon Montessori School

581 Conference Place, Golden, CO 80401 - 303.231.9801 Telephone - 303.231.9983 Fax

Child's Annual Statement of Health Status for Enrollment

According to the Colorado Department of Human Services, the parent or guardian of each child 2 ½ years of age and older, must submit an "**Annual Statement**" of the child's current health status **SIGNED** and dated by an approved health professional who has seen the child within the last 12 months. The statement of health status must be obtained at the time of admission or within 30 days. The health care professional's name, address and phone number must be provided. *All immunizations must be recorded on the Colorado Department of Health Certificate of Immunization.* Non-immunized children or children for whom FHM has no record of immunization due to "opting out" will not be allowed to attend school in the event any admitted student contracts a contagious disease for which immunizations are available, for a length of time TBD based on type of disease. No compensation will be given for students absent or excluded due to health or immunization reasons. ALL new and continuing students must have this form completed annually.

Child's Name: ______________________________ Sex: M___ F___ DOB: ________________

Address: ____

Date of most recent examination of child: ___________________________________

Vision ____________ Hearing ______________ Height _______________ Weight _____

Does this child have frequent:

___ Colds ___ Earaches ___Sore Throats ___Strep ___Other ____________________

Medical Conditions (Check all that apply):

___ Chicken Pox ___Asthma ___Epilepsy ___Diabetes

___Hepatitis ___Fifth's Disease

1) Allergies/Allergic Reactions: ____

2) Special Diets: ____

Chronic illness or handicapping problems: _______________________________________

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3) Describe any health concerns requiring attention by staff (i.e., ADD, ADHD, Sensory Motor Integration, learning differences): _____

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4) Comments and Recommendations to the Staff ________________________________

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Please Print the Following:

Physician's Name: ______________________________ Phone: __________________

Name of Practice: ____

Complete Address: ____

Signature: ____

Physician or Licensed Nurse Practitioner Date