



**International Montessori School of Albania**  
**MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)**

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| <b>I. IDENTIFYING INFORMATION</b>  |           |
| Patient's Name   | Birthdate |
| <b>II. CURRENT STATE OF HEALTH</b>   |           |
| I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH             |           |
| <input type="checkbox"/> ARE <input type="checkbox"/> ARE NOT      SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM. |           |
| DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO                     |           |
| IF YES, EXPLAIN IN SECTION IV.   |           |
| <b>III. IMMUNIZATION HISTORY</b>   |           |
| OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:  |           |

| IMMUNIZATIONS     | DATES GIVEN |            |            |            |            |            |
|-------------------|-------------|------------|------------|------------|------------|------------|
|                   | Dose No. 1  | Dose No. 2 | Dose No. 3 | Dose No. 4 | Dose No. 5 | Dose No. 6 |
| -----DPT/DT/DTAP  |             |            |            |            |            |            |
| ----- Polio       |             |            |            |            |            |            |
| ----- Hepatitis B |             |            |            |            |            |            |
| ----- Hib         |             |            |            |            |            |            |
| ----- MMR         |             |            |            |            |            |            |
| ----- Varicella   |             |            |            |            |            |            |
| ----- other       |             |            |            |            |            |            |

**IV. COMMENTS/RECOMMENDATIONS**  
 (SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

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| SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN | DATE | PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)                     |
| NAME OF CLINIC, GROUP PRACTICE, OTHER   |      | IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME |
| ADDRESS (STREET, CITY, STATE, ZIP CODE)   |      | TELEPHONE NUMBER<br>(       )                                  |

