



DML MONTESSORI SCHOOL OF QUEZON CITY, INC.

46 – 7th St., New Manila – Quezon City

Tel: 722 - 4979 / 722 – 1829

MEDICAL CERTIFICATE

Name of Child: _____

Address: _____

Contact Numbers; _____

Birthday: _____ Age by June: _____

Height: _____ Weight: _____

Name of Family/ Child's Doctor : _____

Evaluation of present general condition: _____

Serious illness or accident to date: _____

History of past illnesses: _____

Known Allergies : _____

Any present medications or treatment: _____

Does the child require exceptional attention and has special needs? _____, please specify his/her

clinically diagnosed conditions _____

If undergoing therapy, please specify _____

Please submit a copy of Clinical Diagnostic Report together with this certificate.

IMMUNIZATION TAKEN AND DATE: (You can also attach the Immunization Chart)

BCG _____

Measles _____

Hepatitis B _____

Chicken pox _____

DPT _____

Hepatitis A _____

OPV _____

MMR _____

HIB _____

Typhoid _____

Others specify _____

Parents / Guardian

THIS IS TO CERTIFY THAT _____

is physically fit to enter school.

Date

Physician's Signature

(Please return as soon as possible)