

Health Care Summary

Must be completed by health care source

Please fax or email to 952-843-5693 or office@schoololl.com

Date of Enrollment: _____

NAME OF CHILD _____ Birth date: _____

ADDRESS _____ Telephone: _____

PARENT (S) OR GUARDIAN: _____

Date of last physical examination? _____ How long have you been seeing this child? _____

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

Does this child have any allergies (including allergies to medications)? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's.... Vision _____

Hearing _____

Speech _____

Please list below the important health problems

<u>Important Health Problems</u>	<u>Following By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program _____

Phone _____

Signature of Health Source _____

Address _____

Date _____
