



Health Care Summary

Must be completed by Health Care Provider

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 a modified diet necessary? _____

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>Followed By You</u>	<u>Followed by Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>

Other information helpful to the child care program _____

Signature of Health Care Provider: _____ Date: _____

Address of Health Care Provider: _____

Phone number of Health Care Provider: _____