HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

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:

Important Health Problems	Followed By You	Followed by Other Med Source (Name)	Requires Special Attention at Center
_____			
_____			

Other information helpful to the child care program_____

_____

_____

Phone_____

Signature of Health Source_____ Address_____

Date_____ _____

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