

Health Care Summary

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

Name of Child: _____ Date of Birth: _____

Address: _____ Telephone (____) _____-_____

Parent(s) or Guardian: _____

Date of last physical examination: _____ How long have you seen this child? _____

How frequently do you see this child when they are 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 important health problems below:

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: _____

Signature of Health Source: _____ **Phone:**(____) _____-_____

Date: _____

Address: _____
