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 any 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 ____________________________ ____________________