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 ATTN AT CENTER

OTHER INFORMATION HELPFUL TO THE CHILD CARE PROGRAM_____

_____

_____

Signature of Health Source_____ Date_____

Phone _____ Address_____