HEALTH CARE SUMMARY
MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Phone _____

PARENT(S)/GUARDIAN(S)_____

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)? _____

List allergies_____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

Describe_____

Health Status

Vision _____
Hearing _____
Speech _____

Please provide information about any important health issues

Health Issue	Followed by Family	Followed by Medical Source (name)	Requires Special Attention at Center
_____			
_____			
_____			

Other information helpful to the child care program _____

_____

_____

Signature of Health Professional _____

Date _____ Phone _____

Address _____
Street City State Zip