



# Health Care Summary

Must be completed by Health Care Provider

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

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed by Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>

Other information helpful to the child care program \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Health Care Provider: \_\_\_\_\_

Phone number of Health Care Provider: \_\_\_\_\_