HEALTH CARE SUMMARY
MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date: _____

ADDRESS: _____

Telephone: _____ Cell Phone: _____

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 attention at Center

Other information helpful to the child care program _____

SIGNATURE OF HEALTH SOURCE _____ Date: _____

Phone: _____

Address: _____