HEALTH CARE SUMMARY

Date of Enrollment: _____________

Name of Child ______________________________ Birth Date _____________________

Address ___________________________________ Telephone ____________________

Parent(s) or Guardians ____

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)?

____

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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

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Signature of Health Source ______________________________ Phone _____________

Address ____

Date _______________________