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

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 Care Provider: _____ Date: _____

Address of Health Care Provider: _____

Phone number of Health Care Provider: _____