

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S)/GUARDIAN _____

Date of last physical exam _____ 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 foods and medications)? _____

Is a modified diet necessary? _____

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

What is the status of the child's Vision _____

Hearing _____

Speech _____

Please list below any health issues that may affect participation in school activities.

Health Issue _____ Requires special attention at school? _____

Other information helpful to the child care program _____

SIGNATURE OF HEALTH SOURCE _____

DATE _____ **PHONE NUMBER** _____

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