

# HEALTH CARE SUMMARY

**MUST BE COMPLETED BY HEALTH CARE SOURCE**

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<br/>By You</u> | <u>Followed By Other<br/>Med Source (Name)</u> | <u>Requires Special<br/>Attention at Center</u> |
|----------------------------------|----------------------------|------------------------------------------------|-------------------------------------------------|
|----------------------------------|----------------------------|------------------------------------------------|-------------------------------------------------|

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

Phone \_\_\_\_\_

**Signature of Health Source** \_\_\_\_\_

Address \_\_\_\_\_

**Date** \_\_\_\_\_