HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

	Date of Enrollment:			
NAME OF CHILD		Bir	Birth Date	
ADDRESS		Telephone		
PARENT(S) OR GUARDIAN				
Date of last physical examination	How	long have you been seeing th	is child?	
How frequently do you see this child wh	en he/she is not ill?			
Does this child have any allergies (includ	ling allergies to med	lications)?		
Is a modified diet necessary?				
Is any condition present that might resu	lt in an emergency?		······································	
What is the status of the child's				
	Hearing			
	Speech			
Please list below the important health p	roblems			
Important Health Problems	Followed <u>By You</u>	Followed By Other <u>Med Source (Name)</u>	Requires Special Attention at Center	
Other information helpful to the child	care program			
,		Рһоле		
Signature of Health Source		Address		
Date				