HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

	Date of Enrollment:			
NAME OF CHILD		B	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 who	en he/she is not ill	?		
Does this child have any allergies (includ	ing allergies to me	dications)?		
Is a modified diet necessary?				
Is any condition present that might result	t in an emergency?	·		
What is the status of the child's	Vision			
	Hearing			
	Speech			
Please list below the important health pro	blems			
Important Health Problems	Followed <u>By You</u>	,	Requires Special Attention at Center	
Other information helpful to the child ca	ıre program			
		Phone		
Signature of Health Source		Address		
Date				