

HEALTH CARE SUMMARY

To be completed by a health care source

Date of Enrollment _____

Name of Child _____ DOB _____

Address _____ Phone _____

Parent(s)/Guardian _____

Date of last physical exam _____

How long have you been seeing this child? _____

How much do you see this child when he/she is not ill? _____

**Does this child have allergies? _____

**Does this child take any medication? _____

**Is this child on a modified diet? _____

**Is any condition present that might result in an emergency? _____

What is the status of this child's:

Vision _____ Hearing _____ Speech _____

List below important health problems. Indicate if you or someone else is following the child for the problem and check which problems will require special care at the center.

Health problem _____

Followed by you/other medical source _____

Requires special attention at the center _____

Other information that may be helpful _____

Health source signature _____ Date _____

Associates or Clinic _____

Address _____