



HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

NAME OF CHILD _____ AGE: _____ BIRTH DATE _____

ADDRESS _____ TELEPHONE _____

LEGAL PARENT(S) OR GUARDIAN _____

Date of last Physical Examination _____ How long have you been seeing this child? _____

MEDICAL HISTORY: Is any condition present that might result in an emergency? YES NO

Explain: _____

Does this child require follow-up for screening tests with abnormal test results? YES NO

Explain: _____

HEALTH CONDITIONS: Does this child have any of the following? If yes, **please attach special instructions.**

- YES NO **Allergy to any Medications: _____
- YES NO **Food Allergies: _____
- YES NO **Environmental Allergies: _____
- YES NO **Special Feeding Needs/Modified Diet: _____
- YES NO **Asthma
- YES NO **Seizures
- YES NO **Diabetes
- YES NO **Special Health Needs: _____
- YES NO Neuromuscular Condition: _____
- YES NO On-Going Health Issue that requires follow-up by you: _____
- YES NO Under Immunized Because of a Medical Condition: _____
- YES NO Hearing Impairment
- YES NO Vision Impairment
- YES NO Speech Impairment
- YES NO High levels of Lead

****Physician MUST attach Care Plans for these conditions as well as Medication Administration.**

IMMUNIZATIONS: Child's **immunizations are up-to-date (documented & attached):** YES NO

If not up-to-date, please attach a plan to bring the child's immunizations current.

Child not immunized for religious reasons. YES NO

Other information helpful to the Child Care Program _____

Signature of Physician _____ Clinic: _____

Phone: _____ **Date** _____