Return Fax to
651-645-8640
CLS/Att. Ms Jackie

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

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program ______________________________

____

____

Phone ______________________________

Signature of Health Source ______________________________ Address ______________________________

Date ______________________________ ______________________________

DHS-0250AA/KS(9-97)