

# HEALTH CARE SUMMARY

ENDLESS JOURNEY CHILD CARE

**MUST BE COMPLETED BY HEALTH CARE SOURCE**

FAX #: 507-281-6603

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

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program: \_\_\_\_\_

Phone \_\_\_\_\_

**Signature of Health Source** \_\_\_\_\_

Address \_\_\_\_\_

**Date** \_\_\_\_\_