All returning students must submit a new Health Care Summary

2017-2018

HEALTH CARE SUMMARY

Class (Please circle)

M-W-F AM | M-W PM

T-Th AM | FULL DAY | T-Th PM

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 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

	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 _____

Return this form to: Shepherd of the Hills Preschool, 3920 N. Victoria St, Shoreview, MN 55126 (FAX:651.483.2296)