Early Childhood Development Center
University of Minnesota, Crookston

Health Care Summary

MUST BE COMPLETED BY HEALTH CARE SOURCE

Name of Child: _____ Date of Enrollment: _____

Birth Date: _____ Phone: _____

Address: _____

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 the important health problem below

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: _____

_____

Name of Health Source: _____

Signature of Health Source: _____ **Date:** _____

Phone: _____ Address: _____

_____