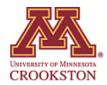
Health Care Summary



MUST BE COMPLETED BY HEALTH CARE SOURCE

Name of Child:		Date o	Date of Enrollment:	
Birth Date:	Phone:			
Address:				
Parent(s) or Guardian:				
ate 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 emer	gency?		
What is the status of the child's				
Vision:				
Hearing:				
Speech:				
Please list the important health pro	oblem below			
Important Health Problems	Followed <u>By You</u>	Followed By Other Med Source (Name)	Requires Special Attention at Center	
Other information helpful to the ch	ild care program:			
Name of Health Source:				
Signature of Health Source:		Date	:	
Phone:	e: Address:			