HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

Name of Child _____ Date of Birth _____

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 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
_____			
_____			

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

_____