# HEALTH CARE SUMMARY

**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 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

| 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** _____ _____

MS-2083

**Please fax this form to Divine Mercy Catholic School at (507) 332-2669. Thank you!!**