COMPLETED FORM IS TO BE TURNED IN TO PRESCHOOL PROGRAM

HEALTH CARE HISTORY
(To be completed by health care source)

Date of Enrollment_____

NAME OF CHILD_____BIRTH DATE_____

ADDRESS_____PHONE(____)_____

PARENT/S OR GUARDIAN_____

Date of last physical examination_____

How long have you been seeing this child?_____

Does this child have any allergies (including allergies to meds?)_____

Is a modified diet necessary?_____

Is any condition present that would result in an emergency?_____

_____

What is the status of the child's . . . . . Vision_____

Hearing_____

Speech_____

Please list below the important health problems.
Indicate if you or someone else is following the child for the problem, and check which problems require special attention at the center.

Important Health Problems	Followed by you	Followed by other Med Source (Name)	Requires Special Attention at Center
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the group day care center_____

_____

_____

_____

Source of health care Associates or clinic

Date_____ Address_____