

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.

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

Other information helpful to the group day care center _____

Source of health care

Associates or clinic

Date _____

Address _____