

***MUST BE COMPLETED BY HEALTH CARE SOURCE**

Date of Enrollment: _____

Child's Name: _____ Birth date: _____

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 or 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 followed by other special requirements:

Important health problems	Followed by You	Followed by other Med Source (Name)	Requires Special Attention at Center
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the child care program: _____

Signature of Health Care Source: _____ Phone: _____

Address: _____