

# Community of Saints Preschool: Health Care Summary



## MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Signature of Parent(s)/Guardian(s): \_\_\_\_\_

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 any important health concerns.

<u>Important Health Concerns</u>	<u>Followed by You</u>	<u>Followed by Other Med. Source</u>	<u>Requires Special Attention at School</u>
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Other information helpful to the program: \_\_\_\_\_

Signature of Health Source: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*The most current immunization record must accompany this form\***