Health Care Summary for Little Beginnings Learning Center

NAME OF CHILD: _____ DOB: _____

ADDRESS: _____ PHONE: _____

PARENT(S) OR GUARDIAN: _____

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of last 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: _____

_____

_____

Signature of Health Source: _____ Address: _____

Date: _____ _____

Phone: _____

FAX to 651-480-3752 or EMAIL to info@littlebeginningslc.com