Wee Pals Fax #: (507)-455-9137

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

NAME OF CHILD: _____ Birth Date: _____

ADDRESS: _____ Telephone: _____

PARENT(S) OR GUARDIAN NAME: _____

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 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: _____ Phone: _____

Date: _____ Address: _____