Health Care Summary

To be completed by your child's primary physician/nurse practitioner

Program Name: St. Pascal's Childhood Learning Center Date of enrollment: ____/____/____

Child's Name: _____ Date of Birth: ____/____/____

Address: _____
Street City State Zip

Parent/Guardian: _____

Date of last physical exam: _____

Is the child up-to-date on their immunizations? _____ Yes _____ No

If no, plan for bringing the child up-to-date? _____

Copy of immunizations attached and signed by health care provider? _____ Yes _____ No

Allergies: _____

Does the child have any important health concerns that you are following them for? _____
_____

Does the child have any important health concerns that are followed by **another** source of health care? (if so, please give name of provider and condition requiring attention)

_____

Does the child have any special needs that require accommodation by the provider? _____
_____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____

Are there any screening tests that are abnormal? _____

If yes, what is the follow-up for abnormal results? _____

Does the child require a different sleep position other than their back? _____

What is the status of the child's Vision: _____ Hearing:_____ Speech: _____

Is there any other information that would be helpful in a group care setting? _____

_____

Primary health care providers name: _____

Clinic Name:_____ Phone#: ( ) _____
Address: _____
Street City State Zip

Signature of Health Care Provider: _____ Date _____

Please attach immunization record