

ALL SAINTS CATHOLIC PRESCHOOL

FAX: 952.469.4484

HEALTH CARE SUMMARY

**(to be completed by your child's health care source and returned by July 31)**

Name of child \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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

Date of last physical examination \_\_\_\_\_

How long have you been seeing this child? \_\_\_\_\_

Does this child have any allergies? (food or meds) \_\_\_\_\_

Is a modified diet necessary? \_\_\_\_\_

Is there any condition present that may result in an emergency? \_\_\_\_\_

What is the status of the child's . . . Speech \_\_\_\_\_

Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Please list below the important health problems.

Indicate if you or someone else is following the child for the problem, and check which problems require special attention at the center.

Health Problem	Followed by You	Followed by other Medical Source	Requires Special Attention
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Other helpful information for the Preschool \_\_\_\_\_

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**PHYSICIAN'S SIGNATURE** \_\_\_\_\_

**CLINIC ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **DATE** \_\_\_\_\_