Health Care Summary For Child Care Attendance

(to be completed by physician/nurse practitioner)

Please complete

Fax to #952-758-5438

Thank you!

Program Name: _ Memories & Milestones Academy _____ Date of enrollment: ___/___/___
Child's Name: _____ Date of Birth: ___/___/___
Address: _____
Street City State Zip Phone No.
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? _____

Does the child require a different sleep position other than on 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 _____