Medical Record and Healthcare Summary

Child's Name: ____ Birth Date: ________________

Address: ____ Phone: ________________

Parent(s) or Guardian: ____ Phone: ________________

THE FOLLOWING IS TO BE COMPLETED BY YOUR CHILD'S PHYSICIAN

Physician: ____ Phone: ________________

Address: ____

Physician's Emergency Hospital Affiliation: ______________________________ Phone: ________________

Date of last physical examination: ____

How long have you been seeing the child? ____

How frequently do you see this child when he/she is not ill? ______________________________________

Does the child have any allergies (including allergies to medication)? ______________________________

Is a modified diet necessary? ____

Is any condition present that might result in an emergency? ______________________________________

What is the status of the following child?

Vision: ____

Hearing: ____

Speech: ____

Please list below any important health problems. Indicate if you, or someone else, are treating the child for the problem, and note which problems require special attention at the center.

Important Health Problems: ____

Treatment: ____

Who is treating the child: ____

Special attention to be given at the Center: ______________________________________

Other significant medical information: ______________________________________

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Physicians Signature: ____ Date: ________________

Address: ____

Please also include the child's current immunization record.

YOU ARE WELCOME TO FAX THE FORM(S) TO US AT 651-484-5453.