MEDICAL RECORD AND HEALTHCARE SUMMARY
(To Be Completed By Healthcare Source)

Child's Name____ Birth date_____________________

Address____ Phone________________________

Parent(s) or Guardian____________________________________ Phone________________________

Physician____ Phone________________________

Physician's Emergency Hospital Affiliation____

THE FOLLOWING TO BE COMPLETED BY THE PHYSICIAN

Date of last physical examination____
How long have you been seeing the child?____
How frequently do you see this child when he 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 is following the child for the problem, and check which problems require special attention at the center.

Important Health problems	Followed by you	Followed by other medical source(name)	Requires special attention at center

Other information helpful to the group day care center_____________________________________
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Physicians Signature____Date___________________
Address____

PLEASE COMPLETE AND SIGN IMMUNIZATION INFORMATION ON REVERSE SIDE

YOU ARE WELCOME TO FAX THE MEDICAL AND IMMUNIZATION RECORD TO US AT 651-407-1078. THANKS!