Healthcare Summary

Child's Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent(s) or Guardian: _____ Phone: _____

Parent Signature _____ Date: _____

By signing above, I authorize disclosure of the following medical information to Children's Discovery Academy.

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

Physician: _____ Phone: _____

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: _____

Physicians Signature: _____ Date: _____

Address: _____

THIS FORM MAY BE FAXED TO CHILDREN'S DISCOVERY ACADEMY AT 651-484-5453.