



## 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 651-407-1078.**