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_____
_____

Physician's Signature_____Date_____
Address_____

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