



**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
651-484-5453. THANKS!**