

# early childhood center

you belong at the center. experience it.

# Health Care Summary

To be completed by physician/nurse practitioner

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Program:    Infant        Toddler        Preschool        Pre-K

Date of last physical exam: \_\_\_\_\_ Is child up-to-date on immunizations?    Yes    No

If no, plan for bringing child up-to-date: \_\_\_\_\_

Copy of immunizations attached and signed by health care provider?    Yes    No

Allergies: \_\_\_\_\_

Does the child have any important health concerns that you are following?  
\_\_\_\_\_

Does the child have any important health concerns that are followed by *another* source of health care?    Yes    No

If yes, please give name of provider and condition requiring attention: \_\_\_\_\_

Does the child have any special needs that require accommodation by the child care center?    Yes    No

If yes, please describe: \_\_\_\_\_

Does the child have any conditions that may result in an emergency?  
\_\_\_\_\_

Does the child have any activity restrictions? \_\_\_\_\_

Is a modified diet necessary? \_\_\_\_\_

Does the child require a different sleep position other than his/her back? \_\_\_\_\_

What is the status of the child's vision: \_\_\_\_\_ hearing: \_\_\_\_\_ speech: \_\_\_\_\_

Is there any other information that would be helpful in a group care setting?  
\_\_\_\_\_

Primary Health Care Provider's name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone : \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_



sabes jcc