



Hourly Childcare

Health Care Summary

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Name of Child _____ Birthdate _____
First Last

Address _____ Phone _____
City, State, Zip

Parent(s) or Guardian _____

Date of last physical examination _____ How long have you been seeing this child? _____

Does this child have any allergies (including allergies to medications?) _____

Is a modified diet necessary? If yes, please explain _____

Is any condition present that might result in an emergency? If yes, please explain _____

What is the status of the child's
Vision _____
Hearing _____
Speech _____

Please list below important health problems which will require special attention at our childcare center.

<u>Important Health Problems:</u>	<u>Followed by (Name/Title)</u>	<u>Requires Special Attention at Center</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is this child developing normal for his/her age? If not, what modifications are needed in the program?

Other information which may be helpful to the child care center: _____

Date Form Signed _____

Health Care Provider Name _____

Health Care Provider Signature _____

Address _____

Phone _____

Please return this completed form to:

**Calvary Hourly Child Care Program
7520 Golden Valley Road Golden Valley, MN 55427
763.545.9042 Fax: 763.545.6953**