SHIRLEY R. ABELSON ALEPH PRESCHOOL

Health Care Summary

To be completed by a physician/nurse practitioner each time a child changes age groups.

Child's Name:_____ Date of Birth:_____
Parent/Guardian:_____ Phone #:_____
Address:_____
Please Check Program: ☐ 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 <u>another</u> 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:_____