

**COMPLETED FORM IS TO BE TURNED IN TO PRESCHOOL PROGRAM**

HEALTH CARE HISTORY  
(To be completed by health care source)

Date of Enrollment \_\_\_\_\_

NAME OF CHILD \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_

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 meds?) \_\_\_\_\_

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

Is any condition present that would result in an emergency? \_\_\_\_\_

What is the status of the child's . . . . . Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

Please list below the 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.

<u>Important Health Problems</u>	<u>Followed by you</u>	<u>Followed by other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the group day care center \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Source of health care

Associates or clinic

Date \_\_\_\_\_

Address \_\_\_\_\_