Kid's Korner EDUCARE CENTER INC.

Health Care Summary:

Child's Name (First, Middle Initial, Last)	
Date of Birth	
Address:	
Parent/Guardian	
Telephone Number	

~The following must be completed by the child's medical physician/pediatrician. ~

How frequently do you see this child when not ill? _____
Date of last visit ___/____/____

Are the immunizations up-to-date? YES NO
If NO, please explain:

Date of last physical examination: ____/_____/_____
What is the status of the child's…
Vision: _____ Hearing: _____ Speech:_____

Does this child have allergies? YES NO
If YES, please explain:

Does this child require medication(s)? YES NO
If YES, please list & why:

Does this child have a Special Dietary Need(s)? YES NO
If YES, please list & complete Special Dietary Form.

Is there a condition present that may result in an emergency? YES NO
If YES, please list:

Please list below any other information regarding heath related concerns, treatments, medications, behavioral, emotional or psychiatric issues which may be helpful to Kid's Korner Educare and our service to the family. Thank you!

_____ _____/_____/_____ _____
Source of Health Care or Clinic **Date** **Physician/Pediatrician Signature**