Our Savior Early Learning Center

HEALTHCARE SUMMARY

MUST BE COMPLETED BY A PHYSICIAN

ENROLLMENT DATE:

CHILD'S NAME: _____ DATE OF BIRTH:_____

PARENT/GUARDIAN: _____

ADDRESS: _____ TELEPHONE: _____

HEALTH CARE PROVIDER: _____

CLINIC: _____ CLINIC ADDRESS: _____

HOW LONG HAVE YOU BEEN SEEING THIS CHILD: _____ DATE OF LAST EXAMINATION: _____

DOES CHILD HAVE ANY ALLERGIES (INCLUDING MEDICATIONS): _____

IS A MODIFIED DIET REQUIRED: YES NO

IF SO, WHAT ARE THE REQUIRED MODIFICATIONS: _____

_____

_____

DOES CHILD HAVE ANY CONDITION THAT MAY RESULT IN AN EMERGENCY? YES NO

STATUS OF CHILD'S

VISION: _____

HEARING: _____

SPEECH: _____

LIST BELOW, ANY IMPORTANT HEALTH CONCERNS. ALSO, LIST THE CARE PROVIDERS TREATING THE CHILD FOR THE DIAGNOSED CONCERN. PLEASE INDICATE WHICH HEALTH CONCERNS MAY REQUIRE SPECIAL ATTENTION BY OSELC STAFF.

HEALTH CONCERN	TREATING PROVIDER	REQUIRES ATTENTION

LIST ANY ADDITIONAL INFORMATION WHICH WOULD BE BENEFICIAL TO OSELC STAFF WHILE PROVIDING CARE FOR THIS CHILD:

_____

_____

_____

PHYSICIAN OR RN SIGNATURE: _____ DATE: _____