Return to fax # 763-543-8636

Health Care Summary For Child Care Attendance

(to be completed by physician/nurse practitioner)

Program Name: Loving Shepherd & Child's Name:	Early Learning	Date of Birth:		
Address:	City	State	Zip	Phone No.
Street Parent/Guardian:			-	
Date of last physical exam:				
Is the child up-to-date on their immunizati		No		
If no, plan for bringing the child up-to-date			***	
Copy of immunizations attached and signed Allergies:				
Does the child have any important health of	concerns that yo	ou are follow	ring them for?	
Does the child have any important health c care? (if so, please give name of provider an	oncerns that ar	e followed b uiring atten	y <u>another</u> sour	rce of health
Does the child have any special needs that	require accomn	nodation by	the provider?	
Does the child have any conditions that ma				
Does the child have any activity restrictions	s?			
Is a modified diet necessary?				
Does the child require a different sleep posi	tion other than	on their bac	ck?	
What is the status of the child's Vision: Hearing:	Speech:			
Is there any other information that would be	e helpful in a gr	oup care se	tting?	
Primary health care providers name: Clinic Name:			#: ()	
Address:		City	State	Zip
Street				-
Signature of Health Care Provider:			Date	