

NOAH'S ARK PRESCHOOL
9185 North Lexington, Circle Pines, MN 55014
763-784-5928

HEALTH CARE SUMMARY

This Health Care Summary MUST be completed and stamped by your Doctor/Clinic

Name of Child _____ Birthdate _____ / _____ / _____

Address _____ Telephone (____) _____ - _____

Parents/s or Guardian _____

Date of last physical examination _____ / _____ / _____

How long have you been seeing this child? _____

How frequently do you see this child when he is not ill? _____

Has this child been to the dentist in the last 6 months? Yes () No ()

If not, when is a dental visit expected to take place? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's:

-vision _____

-hearing _____

-speech _____

List below any 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 preschool:

<u>IMPORTANT HEALTH PROBLEMS</u>	<u>FOLLOWED BY YOU</u>	<u>FOLLOWED BY OTHER MEDICAL SOURCE (name)</u>	<u>REQUIRES SPECIAL ATTENTION AT SCHOOL</u>
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the preschool: _____

Complete the Child Care Immunization Record. Minnesota Statutes Section 123.70 (the Minnesota School Immunization Law, requires that all children who are enrolled in a Minnesota day care facility be immunized against diphtheria, tetanus, pertusis, polio, measles, rubella and mumps, and haemophilus influenza type b. This form will be available for review by the Minnesota Departments of Health and Human Services.

This side of the Health Care Summary MUST be completed and stamped by your Doctor/Clinic. The record of immunization form must be stamped and signed by the child's clinic if the child's immunizations are not up to date. If they are up to date a parent may sign the reverse side of the form. Call the preschool office if you have any questions.

Physician or Clinic - Please stamp and date this box

Date ___/___/___