Print

KID'S HAVEN CHILD CARE & PRESCHOOL
Health Care Summary
Must be completed by health care source

Attention– We can fax this form to your clinic. To do so you must fill out the top part of this form and return it to Kid's Haven. The clinic may need to mail it directly to your home.

Please return by: _____
Please fax back or mail to:
Kid's Haven 763-682-9552 * 302 12th Avenue South – Buffalo, MN 55313
Or mail to child's home

Physician's Name: _____
Clinic Fax Number: _____

Name of Child: _____ DOB: _____ Age: _____

Address: _____ Telephone: _____

Parent/Guardian's Name: _____

Child's Teacher at Kid's Haven: _____

I give my permission for my child's doctor to release this information to Kid's Haven.

_____
Parent Signature

Information below to be completed by Health Care Professional.

Date of last physical exam: _____ How long have you been seeing this child? _____

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

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

_____

Is a modified diet necessary? _____

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

What is the status of the child's…

Vision_____

Hearing_____

Speech_____

Please list below any important health problems. Indicate if you or someone else is following the child for the problem. Also, please check which problems require special attention at the center.

Important health problems	Followed by you	Followed by other med source (Name)	Requires special attention at center
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the child care program _____

Signature of Health Source_____ Phone _____

Date: _____ Address: _____