St. Thomas More Preschool
Health Care Summary
<u>Must Be Completed By Health Care Provider</u>

Name of Child: ___________________________ Birth Date: _____________________

Address: _________________________________ Telephone: _____________________

Parent(s) or Guardian(s): ____

Date of last physical examination: ____

Does this child have any allergies? ____

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

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What is the status of the child's: Vision _____________________________________

Hearing _____________________________________

Speech _____________________________________

Other important information helpful to the child care program ______________________

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Signature of Health Care Provider: ______________________ Date: ________________

Phone: ______________________ Address: ____________________________________

Please attach a copy of the child's certificate of immunization record.