Fax Number: 1-218-681-0244
Mailing Adress: 305 East Nora
Thief River Falls, MN 56701

For Office Use Only
Date of Enrollment: _____
Official Start Date:_____
Classroom:_____

Health Care Summary – MUST BE COMPLETED BY HEALTH CARE SOURCE
Form needs to be returned to Discovery Place within 30 days following enrollment.

Name of Child: _____ DOB: _____

Address: _____

Parent(s) or Guardian (s):_____ Phone: _____

Date of last Physical Examination: _____ 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 allergies to medications)?_____

Is a modified diet necessary? _____

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

_____

Provide status of child's:

Vision:_____

Hearing:_____

Speech:_____

Please list all important health problems below:

Health Problem (A):_____

Followed by you: _____ Another Medical Source:_____

Requires Special Attention at Center: _____

_____

Health Problem (B): _____

Followed by You: _____ Another Medical Source: _____

Requires Special Attention at Center:_____

_____

Other helpful information for the childcare program: _____

_____

_____

Signature of Health Source: _____ Date:_____

Address: _____ Phone: _____

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