**Parent/Guardian: Please sign & give to your health care provider.**
**Health Care Provider: Please complete and return to:**
**Lake Harriet UM Preschool 4901 Chowen Av. S. Minneapolis MN 55410 Fax: 612.926.7646**

| **Health Care Summary**<br>**(To be signed by parent/guardian & completed & signed by health care provider)** | **Program Enrollment Date:**<br>September 2018 |
|---|---|

| Child's Name: | Birth Date: | Height (Percentile): | Weight (Percentile): |
|---|---|---|---|
| Address: | | Phone Number: | |

**I authorize the sharing of my child's health information with Lake Harriet UM Preschool.** **Parent/Guardian Signature:**

**Physical Findings – (N = NORMAL; AB = ABNORMAL)**

| Area: | N/AB: | Comments: | Area: | N/AB: | Comments: |
|---|---|---|---|---|---|
| 1. Head | | | 11. Cardiovascular | | |
| 2. Face | | | 12. Abdomen | | |
| 3. Neck | | | 13. Genitals | | |
| 4. Eyes | | | 14. Extremities | | |
| 5. Ears | | | 15. Joints | | |
| 6. Nose | | | 16. Muscle Tone | | |
| 7. Mouth | | | 17. Skin | | |
| 8. Throat | | | 18. Neurological | | |
| 9. Chest | | | 19. VISION | | |
| 10. Spine | | | 20. HEARING | | |

**Lab Findings:**

| Hemoglobin/Hematocrit: | Urinalysis: | Sickle Cell: | Blood Lead: | Mantoux: | Other: |
|---|---|---|---|---|---|
| | | | | | |

1. Assessments: _____
2. Does this child have ALLERGIES? ☐ No ☐ Yes – Specify: _____
   Recommendations: _____
3. Is there a condition which may result in an emergency: ☐ No ☐ Yes – Specify: _____
   _____
   Emergency Plan: _____
   _____

4.

| Important Health Problems: | Followed By (Name & Title): | Special Care Needed In Childcare Program: |
|---|---|---|
| | | |
| | | |
| | | |

5. Is this child developing appropriately for his/her age? ☐ Yes ☐ No – If not, what modifications in the Childcare Program are needed:
   _____
   _____
6. Nutrition: Is a special diet necessary: ☐ No ☐ Yes Type of formula: _____ Until what age? _____
   Milk (Whole, 2%, etc.): _____ Age for introduction of solid foods: Meat _____ Fruit _____ Eggs _____
   Orange Juice _____ Cereal _____ Vegetables _____ Table Foods _____

| How Long Have You Been Seeing This Child: | Name Of Clinic, If Applicable: |
|---|---|
| Address: | Telephone Number: |

| Signature of Health Care Provider: | Date Of Exam: | Date Form Completed: |
|---|---|---|
| | | |