

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 (To be signed by parent/guardian & completed & signed by health care provider)	Program Enrollment Date: September 2020
--	---

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:
------------------------------------	---------------	----------------------