FORM H-300

Health Care Summary

(to be completed by physician/nurse practitioner)

Program Name: Wee Care Day Care Date of enrollment: __/__/__
Child's Name: _____ Date of Birth: __/__/__
Address: _____
Street City State Zip Phone No.
Parent/Guardian: _____

Date of last physical exam: _____
Is the child up-to-date on their immunizations? ☐ Yes ☐ No
If no, plan for bringing the child up-to-date _____

Copy of immunizations attached and signed by health care provider? ☐ Yes ☐ No
Allergies: _____
Does the child have any important health concerns that you are following them for? _____

Does the child have any important health concerns that are followed by another source of health care? (if so, please give name of provider and condition requiring attention) _____

Does the child have any special needs that require accommodation by the provider? _____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____
Does the child require a certain sleep position? _____
What is the status of the child's Vision: _____
Hearing: _____ Speech: _____
Is there any other information that would be helpful in a group care setting? _____

Primary health care providers name: _____
Clinic Name: _____ Phone #: ( ) _____
Address: _____
Street City State Zip

Signature of Health Care Provider: _____