Community Child Care Center

1250 Fifield Ave Saint Paul, MN 55108
Phone (651) 645-8958 Fax (651) 645-2295

Health Care Summary

Name	DOB:	Gender: ☐ M ☐ F

Is child up to date with C&TC including all required tests?: ☐ Yes ☐ No

Are immunizations up to date? *(Please attach a copy)* : ☐ Yes ☐ No

Height: in. Weight: lbs. ☐ No concern ☐ Concern

Blood Pressure: _______ / _______ ☐ Concern ☐ No Concern

Vision Status: ☐ No Concern ☐ Concern ☐ Unable ☐ Refer

R 20/ _______ L 20/ _______ Corrected: ☐ Yes ☐ No

Hearing Status ☐ No Concern ☐ Concern ☐ Unable ☐ Refer

	500 (25)	1000 (20)	2000 (20)	4000 (20)
Right				
Left				

*Required by HS. Previous dates acceptable

*Lab	Date	Results	Comments
*Hemoglobin			
*Blood Lead Level			

Area	N	AB	Comments	Area	N	AB	Comments
General Appearance				Lungs			
Head				Abdomen			
Face				Genitourinary			
Eyes				Musculoskeletal			
Ears				Spine			
Mouth-Teeth				Extremities			
Throat				Skin			
Nose				Neurological			
Neck				Nutritional Status			
Cardiovascular				Emotional Status			
Chest				Speech			

Allergies:

Routine Medications:

Is child developing appropriately for his/her age? ☐ Yes ☐ No, please specify:

Is a special diet necessary? ☐ No ☐ Yes, please specify:

Is there a condition that may result in an emergency? ☐ No ☐ Yes, please specify:

Is there a condition that may interfere with learning? ☐ No ☐ Yes, please specify:

Please indicate any present health conditions:

Any restrictions or recommendations:

*C&TC Exam Date:

Signature of Heath Care Provider: Date Signed:

Print Name:

Clinic Name: Phone #:

Address: Fax #:

Signature of Parent/Caregiver Authorizing Health Care Provider to release this information:	Date: