

# Ark of Angels Montessori Preschool Health Care Summary

Today's Date \_\_\_\_\_

Childs Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

Date of last physical \_\_\_\_\_

How long has this child been your patient? \_\_\_\_\_

List all allergies including medication allergies

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List any Dietary Restrictions

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Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

List any Health problems that the child care center should be aware of

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***PHYSICIANS SIGNATURE*** \_\_\_\_\_

Physicians Name \_\_\_\_\_

Clinic address \_\_\_\_\_

Clinic Phone # \_\_\_\_\_