



Health Care Summary

To be completed by health care provider. Must be returned within 30 days of enrollment date.

Today's Date: _____ Enrollment Date: _____

Name of Child: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent/Guardian: _____

Date of last physical examination: _____ Is a modified diet necessary? _____

Does the child have allergies? _____ Allergic to any medications? _____

Does the child have any condition(s) that might result in an emergency? _____

Does the child require a different sleeping position other than on their back? _____

What is the status of the child's... Vision? _____

Hearing? _____

Speech? _____

Please list any important health problems below. Indicate if anyone is following up on the problem, and which problems need special treatment or care by Playworks.

Important Health Problems	Followed by You	Followed by Other Source	Required Special Care by Playworks

Other health information that would be helpful in a group care setting: _____

Health Care Provider's Signature: _____ Clinic: _____

Provider's Fax Number: () _____ Date: _____

Please return this form via fax at 952.496.6820

playworksfun.com

2200 Trail of Dreams • Prior Lake, MN 55372 • 952.445.PLAY (7529)
SMSC Infant and Toddler Classroom • 2330 Sioux Trail • Prior Lake, MN 55372 • 952.496.6124

Owned and Operated by the Shakopee Mdewakanton Sioux Community