DCLC Fax#: 703-788-5772

Health Care Summary For Child Care Attendance

FORM H-300

(to be completed by physician/nurse practitioner)

Program Name: _____ Date of enrollment: __/__/__

Child's Name: _____ Date of Birth: __/__/__

Address: _____
Street City State Zip

Parent/Guardian: _____ Phone No.

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: _____

Date!