

# Health Care Summary

**Trinity Nursery School**  
609 S. Lincoln Ave., Owatonna, MN 55060

**Please have this form completed and signed by your health care provider and return it to your teacher at the home visit prior to the first day of school.**

	Enrollment Date _____
NAME OF CHILD _____	Birth Date _____
Address _____	Telephone _____
Parents/Guardians _____	

**NOTE: Licensing law requires that your child has had a physical since his/her 3<sup>rd</sup> birthday.**

Date of this child's last physical examination \_\_\_\_\_

How long have you been seeing this child? \_\_\_\_\_

Does this child have any allergies (including allergies to medication?) \_\_\_\_\_

Is a modified diet necessary? \_\_\_\_\_

Is any condition present that may result in an emergency? \_\_\_\_\_

What is the status of the child's . . . . . Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

Please list below any important health problems. Indicate if you or someone else is following the child for the problem, and check which problems may require special attention at Trinity Nursery School.			
Important Health Problems	Followed by you	Followed by another Medical Source (name)	Requires Special Attention at TNS
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to Trinity Nursery School \_\_\_\_\_

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Signature of Health Care Provider \_\_\_\_\_

Associates or Clinic \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_