HEALTH CARE SUMMARY

1. All Information below must be completed and ***signed by*** *your child's* ***doctor***.
2. Return this form to:
   Address: *Kingdom Kids Preschool, 4400 55th Street NW, Rochester, MN 55901*
   Fax*: 507-286-1278*
3. This form must be received within 30 days of your child's first day of attendance.

Patient's Name:_____ **Birth Date:** _____
Month day year

Most recent Well Child Exam: _____
Month day year

Height:_____**(In/Cm) Weight:** _____**(lb/kg)** **Blood Pressure:** _____/_____

1. Significant past medical history**: NO ( ) YES ( )**
If yes, please explain: _____

2. Significant emotional developmental findings: **NO ( ) YES ( )**
If yes, please explain: _____

3. Significant physical findings: **NO** ( ) **YES** ( )
If yes, please explain: _____

4. Hearing Screen: _____ Vision Screen: _____

5. Allergies: **NO** ( ) **YES** ( ) **If yes, please list:** _____

6. Medications: **NO** ( ) **YES** ( ) List: _____

7. Immunizations complete for age of child? **NO ( )**† **YES ( )**

8. **Please attach a copy of this child's immunization report**.
This must be on file before your child can attend preschool.
All immunizations must be current unless you provide a notarized statement indicating your opposition.

Physician recommendations or comments if any:

_____
_____
_____
_____
_____

Physician's Signature: _____ **Date:** _____

Printed Name: _____ **Physician's Phone:** _____
Physician/Pediatrician