

**Triumph Lutheran Brethren's  
Little Lights Preschool  
Health Care Summary  
Must Be Returned by October 1**

**Must Be Completed by Health Care Source**

Name of Child \_\_\_\_\_ Date of Enrollment \_\_\_\_\_  
Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Parent(s) or Guardian \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ How long have you been seeing this child? \_\_\_\_\_

How frequently do you see this child when he/she is not ill? \_\_\_\_\_

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

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

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

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

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

Please list below the important health problems:

Important Health Problems	Followed by You	Followed by Other Med. Source (name)	Requires Special Attention at Center
_____	_____	_____	_____
_____	_____	_____	_____

Other Information helpful to the child care program: \_\_\_\_\_

**Signature of Health Source** \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**(Please complete the back.)**

## Health History of Child

(To be filled out by Parent or Guardian before child is examined.)

Please indicate "yes" if your child has any of the following:

Frequent colds, sore throats \_\_\_\_\_

Headaches \_\_\_\_\_

Frequent earaches and infections \_\_\_\_\_

Seizures \_\_\_\_\_

Speech difficulties \_\_\_\_\_

Hay Fever \_\_\_\_\_

Poor sleeping habits \_\_\_\_\_

Asthma \_\_\_\_\_

Poor eating habits \_\_\_\_\_

Eczema \_\_\_\_\_

Any unusual problems: \_\_\_\_\_

Any allergies (including food): \_\_\_\_\_