Form H-300 **To be completed by physician/nurse practitioner**

Health Care Summary For Child Care Attendance

Program Name: ______________________ Date of enrollment: ____/____/____
Child's name: ______________________ Date of Birth: ____/____/____
Address ______________________
Street City State Zip Phone No.
Parent /Guardian: ______________________

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? ☐ Yes ☐ No If yes, please explain ______________

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? ______________

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Primary Health Care Provider's Name: ______________________
Clinic Name: ______________________ Phone #: (_____)______________
Address: ______________________
Street City State Zip
Signature of Health Care Provider: ______________________ Date: __________