ST. EDWARD School/Preschool
STUDENT HEALTH SUMMARY FORM
****Must be completed by Health Care Provider****

Child's Name: ________________________________ **Date of Birth:** ____________ **Male** □ **Female** □

Parent/Guardian: Name: ________________________ Number: ____________________

Student's Doctor: _______________________ Clinic: ___________________ Number: _________________

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 medication allergies)? ___________________________________

Is a modified diet necessary? ____

Is any condition present that might result in an emergency? ____
____

MEDICATIONS: List medications prescribed with reason for the medication:
____
____
____

What is the status of the child's... Vision ____

Hearing ____

Speech ____

Please list below the health problems/concerns:

Problems/Concerns | Requires Special attention at school? Explain...

- ____
- ____
- ____

Other information helpful to the child care program ____
____
____
____

Signature of Healthcare Provider: ___________________________________ **Date:** ______________

Thank you for completing this form!

(Form to be kept in student health file)