

STUDENT HEALTH CARE SUMMARY FORM

(Must be completed by child's health care provider)

Enrollment Date: _____

Child's Full Name _____ Birth Date _____

Address _____ Phone _____

Parents/Guardian Names: _____

Date of last physical exam: _____ 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:

| Health Problem | Followed by you? | Followed by Other Medical Professional? (please list name) | Requires Special Attention at School? |
|----------------|------------------|---|---------------------------------------|
| | | | |
| | | | |
| | | | |

Please provide any other information that would be helpful to the school program.

Health Care Provider Name

Health Care Provider Signature

Clinic Address _____

Date completed: _____

Please complete form and return to Talmud Torah of St. Paul, 768 Hamline Avenue S,
St. Paul, MN 55116-2224 or fax to 651-698-8912 BEFORE Friday, August 22, 2011.