



# 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 55<sup>th</sup> 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** ( )<sup>†</sup> **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