



WOODDALE ACADEMY

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WOODDALE ACADEMY, EDINA

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

NAME OF CHILD _____ AGE: _____ BIRTH DATE _____

ADDRESS _____ TELEPHONE _____

LEGAL PARENT(S) OR GUARDIAN _____

Date of last Physical Examination _____ How long have you been seeing this child? _____

MEDICAL HISTORY: Is any condition present that might result in an emergency? YES NO

Explain: _____

Does this child require follow-up for screening tests with abnormal test results? YES NO

Explain: _____

HEALTH CONDITIONS: Does this child have any of the following? If yes, please attach special instructions.

YES NO **Allergy to any Medications: _____

YES NO **Food Allergies: _____

YES NO **Environmental Allergies: _____

YES NO **Special Feeding Needs/Modified Diet: _____

YES NO **Asthma _____

YES NO **Seizures _____

YES NO **Diabetes _____

YES NO **Special Health Needs: _____

YES NO Neuromuscular Condition: _____

YES NO On-Going Health Issue that requires follow-up by you: _____

YES NO Under Immunized Because of a Medical Condition: _____

YES NO Hearing Impairment _____

YES NO Vision Impairment _____

YES NO Speech Impairment _____

YES NO High levels of Lead _____

YES NO Food Sensitivity _____

****Physician MUST attach Care Plans for these conditions as well as Medication Administration.**

IMMUNIZATIONS: Child's immunizations are up-to-date (documented & attached): YES NO

If not up-to-date, please attach a plan to bring the child's immunizations current.

Child not immunized for religious reasons. YES NO

Other information helpful to the Child Care Program _____

Signature of Physician _____ Clinic: _____

Phone: _____ Date _____