LOYOLA CATHOLIC SCHOOL

Preschool Health Care Summary

(Must be completed by health care source and returned by the first day of school)

Date of Enrollment _____

Name of child _____ Birth date _____

Address _____ Telephone _____

Parent(s) or Guardian(s) _____

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 medications? _____ If yes, explain below

Is a modified diet necessary? _____

Is any condition that Loyola Staff should be made aware of _____

What is the status of the child's: Vision _____

Hearing _____

Speech _____

Signature of Health Source _____

Date _____

Phone number _____ Address _____

If returning via FAX, please send to: Loyola Upper Campus 507.388.3081