Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

Health Care Summary
(To be completed by health care provider)

Program Enrollment Date:

Child's Name:	Birth Date:	Height (Percentile):	Weight (Percentile):
Address:		Phone Number:	

Physical Findings – (N = NORMAL; AB = ABNORMAL)

Area:	N/AB:	Comments:	Area:	N/AB:	Comments:
1. Head			11. Cardiovascular		
2. Face			12. Abdomen		
3. Neck			13. Genitals		
4. Eyes			14. Extremities		
5. Ears			15. Joints		
6. Nose			16. Muscle Tone		
7. Mouth			17. Skin		
8. Throat			18. Neurological		
9. Chest			19. VISION		
10. Spine			20. HEARING		

Lab Findings:

Hemoglobin/Hematocrit:	Urinalysis:	Sickle Cell:	Blood Lead:	Mantoux:	Other:

1. Assessments: _____
2. Does this child have ALLERGIES? ☐ No ☐ Yes – Specify: _____
   Recommendations: _____
3. Is there a condition which may result in an emergency: ☐ No ☐ Yes – Specify: _____
   _____
   Emergency Plan: _____
   _____

4.

Important Health Problems:	Followed By (Name & Title):	Special Care Needed In Childcare Program:

5. Is this child developing appropriately for his/her age? ☐ Yes ☐ No – If not, what modifications in the Childcare Program are needed:
   _____
   _____
6. Nutrition: Is a special diet necessary: ☐ No ☐ Yes Type of formula: _____ Until what age? _____
   Milk (Whole, 2%, etc.): _____ Age for introduction of solid foods: Meat _____ Fruit _____ Eggs _____
   Orange Juice _____ Cereal _____ Vegetables _____ Table Foods _____

How Long Have You Been Seeing This Child:	Name Of Clinic, If Applicable:
Address:	Telephone Number:

Signature of Health Care Provider:	Date Of Exam:	Date Form Completed: