

**Minnesota Visiting Nurse Agency**

3433 Broadway Street NE, Suite 300  
 Minneapolis, MN 55413

<b>Health Care Summary</b> (To be completed by health care provider)	<b>Program Enrollment Date:</b>
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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:
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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: \_\_\_\_\_

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:
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