Name of Clinic to be mailed to:____

I authorize the release of the following child's health information to Teddy Bear Care. My child sees Dr._________________. Please return these forms within 15 days to:

☐ Teddy Bear Care on 65, Inc.
1438-215th Avenue NE
East Bethel, MN 55011
Ph:(763)434-1980
Fax: (763)434-5624

☐ Teddy Bear Care of Isanti, Inc.
302 Credit Union Drive
P.O. Box 516
Isanti, MN 55040
Ph:(763)444-3774
Fax: (763)444-3774

Any questions, please call. Thank You.

Parent Signature__________________________ Teddy Bear Care Director_________________

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: ________________

NAME OF CHILD ____ Birth Date __________________

ADDRESS ____ Telephone _________________

PARENT(S) OR GUARDIAN ____

Date of last physical examination ____________ 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 allergies to medications)? ____________________________

Is a modified diet necessary? ____

Is any condition present that might result in an emergency? ______________________________________

____

What is the status of the child's. . .

Vision ____

Hearing ____

Speech ____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program ____

____

Phone ______________________________

Signature of Health Source __________________________ Address ______________________________

Date ____________________ ______________________________________