ST. JOHN
LUTHERAN CHURCH & SCHOOL

Health Care Summary

MUST BE COMPLETED BY HEALTHCARE PROFESSIONAL or the Parents of the Student

NAME OF CHILD: _____ BIRTH DATE: _____

ADDRESS: _____ TELEPHONE: _____

PARENT(S) OF GUARDIAN: _____

Date of last physical examination _____ How long have you seen this child: _____

Does this child have any allergies (including allergies to medication)? _____

_____

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 any current health problems:

Followed by You Followed by other Medical Professional Requires Special Attention

_____

_____

_____

Other information helpful to treatment or care for this child:

_____

_____

MEDICAL INSTITUTION: _____

SIGNATURE OF HEALTHCARE PROFESSIONAL: _____ DATE: _____

ADDRESS: _____ PHONE: _____

FORM CAN BE REMITTED TO: **MAIL:** St. John's Lutheran School, 206 Plum Road, Wrightstown, WI 54180

EMAIL: Office@stjohnwrightstown.com