

GENERAL HEALTH APPRAISAL FORM Birth to School

PARENT: Please Complete

Child's Name _____ Birthdate _____

Allergies None or Describe _____

Type of Reaction _____

Diet: Breast Fed Formula _____ Age Appropriate

Special Diet _____

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding..

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's child care provider. FAX #: _____

Parent or Legal Guardian Signature Date: _____
Authorization expires 365 days after this date

HEALTH CARE PROVIDER: Please Complete After Parent Section

Date of Last Exam _____ Recent Weight _____ ** HCT _____ ** B/P _____ **Lead Level: _____

**Tuberculosis Status: Not indicated Date done: _____ Results: _____

Physical Exam: Normal Abnormal (see explanation of significant health concerns:)

Significant Health Concerns: None Reactive Airway Disease Seizures Diabetes Developmental Delays

Vision Hearing Hospitalizations Severe Allergies Other (dental, nutrition, behavior, etc.) _____

Explain above concerns (if necessary, include instructions to child care providers): _____

Current Medications/Special Diet: None Describe _____

(Separate medication authorization form required for medications given in Child Care, School or Camp)

For fever reducer or pain reliever (mark only one product: max. 3 consecutive days without additional medical authorization)

Acetaminophen (Tylenol) may be given for pain or for fever° over 102° every 4 hours as needed:

Dose _____ See attached Dosage Schedule from our office

OR

Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102° every 6 hours as needed

Dose _____ See the attached Dosage Schedule from our office.

Immunizations: See attached immunization record

Signature

Next Well Visit: Per AAP guidelines* or Age _____

This child is healthy and may participate in all routine activities, sports, camps and child care. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) Date

Office Stamp

Or write Name,
Address, Phone

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/04

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** This is required by Head Start programs only per EPSDT schedule.