2021-2022 General Health Appraisal Form

(Preschool, Sports, After School Program – one form per student every year)

Parent: Please complete the following section and give to current health care provider for completion

Child's Name ______________________ Birthdate ______________

Allergies: ☐ None ☐ Describe: ______________________

Type of Reaction: ______________________

Diet: ☐ Age Appropriate ☐ Breast Fed ☐ Formula: ______________

☐ 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 care provider, school, or camp personnel to discuss my child's health concerns. My child's health care provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. **Fax number: 303-321-7765.**

______________________ Date: ______________

Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: Please complete, sign at bottom, and return to parent or fax to above number.

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

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

Significant Health Concerns: ☐ None ☐ Reactive Airways Disease ☐ Seizures ☐ Diabetes ☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Hospitalizations ☐ Severe Allergies ☐ Other *(dental, nutrition, behavior, etc.)* ________

Explain above concerns (if necessary, include instructions to childcare providers): ______________________

____

Current Medications/Special Diet: ☐ None ☐ Describe: ______________________

____

(Separate medication authorization form required for medications given in Child Care)

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 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 fever over 102° every 6 hours as needed:
Dose ______________ ☐ See attached Dosage Schedule from our office

Immunizations: ☐ Up-to-date ☐ See attached immunization record ☐ Administered today:

____

Signature: Office Stamp: or write Name, Address, Phone Number

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

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Head Start 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.
** Required by Head Start programs only per state EPSDT schedule.
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