GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name:______________________ **Birthdate:** ____________

Allergies: ❑ None or Describe______________________

Type of Reaction ______________________

Diet: ❑ **Breast Fed** ❑ **Formula** ____________ ❑**Age Appropriate**

❑**Special Diet** ______________________

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

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

I, ______________ **give consent for my child's care health provider, school child care 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 school, child care or camp personnel. FAX #:** ____________ **DATE:** ____________

Parent/Guardian Signature______________________

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: ____________ **Weight @ Exam:** ____________

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities)______________

Allergies: ❑ None or Describe____________ Type of Reaction ____________

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other ____________

Explain above concern (if necessary, include instructions to care providers): ____________

Current Medications/Special Diet: ❑ None or Describe ____________

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

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

Dose ____________ or see the attached age-appropriate dosage schedule from our office

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

Dose ____________ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: ____________

Health Care Provider: Complete if Appropriate

ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE

** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _______ **

** HCT/HGB _____ ** Lead Level ❑Not at risk or Level _____

**TB ❑Not at risk or Test Results ❑ Normal ❑ Abnormal

**Screenings Performed: ❑Vision: ❑Normal ❑Abnormal ❑Hearing: ❑Normal ❑Abnormal ❑Dental: ❑Normal ❑Abnormal-

Recommended Follow-up______________________

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age_________

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

Appraisal Expires May 31, 2021

____

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. 04/07

*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.

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