GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name:	Birthdate:		
Diet: 🛛 Breast Fed 🗳 Formula			
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			

<u>HEALTH CARE PROVIDER:</u> Please Complete After Parent Section Completed

Date of Last Health Appraisal: Weight @ Exam:		
Physical Exam: Dormal Dormal (Specify any physical abnormalities)		
Allergies: D 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: D 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 Ubuprofen (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: Dup-to-Date Des attached immunization record DAdministered 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: Der 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.

Office Stamp Or write Name, Address, Phone, #

Signature of Health Care Provider (certifying form was reviewed)

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.

Date:

Copyright 2007 Colorado Chapter of the American Academy of Pediatrics