

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.

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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