GENERAL HEALTH APPRAISAL FORM

PARENT please complete and SIGN

Child's Name: ____ **Birth date:** ________________________

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 may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, ________________________________, give consent for my child's health provider and child care 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 personnel. **FAX#: 303-476-6785**

Parent/Guardian Signature: _______________________________________ **Date:** ___________________________________

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 health concern: ____

Current Medications/Special Diet: ☐ **None or Describe** ____

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

For Fever Reducer or Pain Reliever (for 3 consecutive days w/o 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 ☐ Ibuprofen (Motrin, Advil) may be given for pain relief or for fever over 102 degrees every 6 hours as needed

Dose ________________________

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

Provider Signature

Next Well Visit: ☐ **Per AAP Guidelines* or** ☐ **Age________**

This child is healthy and may participate in all routine activities at child care.

Any concerns or exceptions are identified on this form.

____

Signature of Health Care Provider Date: _______________

Office Stamp

Or write Name, Address, and Phone #

*The AAP (American Academy of Pediatrics) recommends that children from ages 0-12 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.