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 health care 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: ☐Sever Allergies ☐ Reactive Airway Disease ☐Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations
☐ Developmental Delays ☐ Behavior Concerns ☐ Vision ☐Hearing ☐ Dental ☐ Nutrition ☐ Other _____
Explain above concern (if necessary, include instruction 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 addition 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

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.

_____Date_____
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.
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