

## 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 @ Last 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

**OR** Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office

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 expectations are identified on this form.

\_\_\_\_\_  
Signature of Health Care provider (certify 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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