GENERAL HEALTH APPRAISAL FORM

Child’s Name: ___________________________ Birthdate: ___________________________

Allergies: □ None or Describe ___________________________ □ Age Appropriate

Type of Reaction ___________________________

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: ___________________________

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 ___________________________ □ Age Appropriate

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 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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