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 attachment) 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.

_____

Provider Signature Date

Office Stamp

Or write Name, Address, Phone, #