Due 30 Days after first day. **GENERAL HEALTH APPRAISAL FORM** SonShine Preschool Fax: 970-352-2769

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 @ 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.

_____

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.