

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 @ 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, #