

# 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, #  
CHILDREN'S MEDICAL CENTER P.C.  
1818 N OGDEN STREET, SUITE 300  
DENVER, CO 80218

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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