

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: _____	Birthdate: _____
Allergies: <input type="checkbox"/> None or Describe _____	
Type of Reaction _____	
Diet: <input type="checkbox"/> Breast Fed <input type="checkbox"/> Formula _____ <input type="checkbox"/> Age Appropriate	
<input type="checkbox"/> Special Diet _____	
Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.	
<input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify any physical abnormalities) _____	
Allergies: <input type="checkbox"/> None or Describe _____ Type of Reaction _____	
Significant Health Concerns: <input type="checkbox"/> Severe Allergies <input type="checkbox"/> Reactive Airway Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Hospitalizations <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Behavior Concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Dental <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____	
Explain above concern (if necessary, include instructions to care providers): _____	
Current Medications/Special Diet: <input type="checkbox"/> None or Describe _____	
Separate medication authorization form is required for medications given in school, child care or camp	

Provider Signature

Next Well Visit: <input type="checkbox"/> Per AAP guidelines* or <input type="checkbox"/> 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, #