

# GENERAL HEALTH APPRAISAL FORM

## PARENT

Please complete, date, and SIGN.

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Allergies:  None OR  List food/medication: \_\_\_\_\_

Diet:  Breastfed  Age appropriate  Special-Describe: \_\_\_\_\_

Skin Care:  Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

Sleep: Your healthcare provider recommends that all infants less than 1 year of age be placed on their back for sleep.

I, \_\_\_\_\_, give permission for my child's healthcare provider to share this form and applicable attachments with my child's school, childcare, or camp. Contact information for the person to receive this form:

Name: SONSHINE PATCH PRESCHOOL Fax: NA Email: DAISY@SONSHINEPATCHPRESCHOOL.COM

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH CARE PROVIDER

Please complete after parent section has been completed.

Date of most recent health appraisal: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Physical Exam:  Normal  Abnormal-describe: \_\_\_\_\_

Allergies:  None OR  List food/medication: \_\_\_\_\_ Type of Reaction \_\_\_\_\_

Current Medications:  None OR  List: \_\_\_\_\_

A separate medication authorization form ([link](#)) is required for medications given in school, childcare, or camp.

Current Diet:  Breastfed  Age appropriate  Special-describe: \_\_\_\_\_

A separate diet statement ([link](#)) is required for food provided at school, childcare, or camp.

Health Concerns:  Severe Allergies  Asthma  Seizures  Diabetes  Hospitalizations  Behavior Concerns

Developmental Delays  Vision  Hearing  Oral Health  Under/Overweight  Other: \_\_\_\_\_

Explain above concerns (if necessary, include instructions to care providers): \_\_\_\_\_

Immunizations:  See attached immunization record or official exemption form  Next vaccine due date: \_\_\_\_\_

## HEALTH CARE PROVIDER

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.

Height: \_\_\_\_\_ B/P: \_\_\_\_\_ Head Circumference (up to 12 months): \_\_\_\_\_ HCT/HGB: \_\_\_\_\_

Lead Level:  Not at risk OR  Lead level: \_\_\_\_\_ TB:  Not at risk OR Test Result:  Normal  Abnormal

Screens Performed:  Vision:  Normal  Abnormal  Hearing:  Normal  Abnormal

Oral Health:  Normal  Abnormal Developmental Screen:  ASQ  PEDS  Other: \_\_\_\_\_

Developmental Concerns: \_\_\_\_\_ 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, childcare, or camp. Any concerns or exceptions are identified on this form.

\_\_\_\_\_  
Signature of Healthcare Provider (certifying form reviewed)

\_\_\_\_\_  
Date

\*The AAP recommends Well Child Visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, and annually after 3 years.

## OFFICE STAMP

Or write Name, Address, Phone Number, Email