

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: CSU Early Childhood Center Fax: 970-491-7493 Email: eccinfo@colostate.edu

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

