

# General Health Appraisal Form

## Parent: Please complete

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

Allergies:  None  Describe: \_\_\_\_\_

Type of Reaction: \_\_\_\_\_

Diet:  Breast Fed  Formula: \_\_\_\_\_  Age Appropriate

Special Diet: \_\_\_\_\_

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding.

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

I, \_\_\_\_\_ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian Signature Date: \_\_\_\_\_  
Authorization expires 365 days after this date

## Health Care Provider: Please complete after parent section has been completed

Date of Last Exam: \_\_\_\_\_ Recent Weight: \_\_\_\_\_ \*\*HCT: \_\_\_\_\_ \*\* B/P: \_\_\_\_\_ \*\*Lead Level: \_\_\_\_\_

Physical Exam:  Normal  Abnormal (see explanation of significant health concerns:)

Significant Health Concerns:  None  Reactive Airways Disease  Seizures  Diabetes  Developmental Delays  
 Vision  Hearing  Hospitalizations  Severe Allergies  Other (dental, nutrition, behavior, etc.) \_\_\_\_\_

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

Current Medications/Special Diet:  None  Describe: \_\_\_\_\_

(Separate medication authorization form required for medications given in Child Care)

**Fever reducer or pain reliever (mark only one product: max. 3 consecutive days without additional medical authorization)**

Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:  
Dose \_\_\_\_\_  See attached Dosage Schedule from our office

OR

Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:  
Dose \_\_\_\_\_  See attached Dosage Schedule from our office

Immunizations:  Up-to-date  See attached immunization record  Administered today: \_\_\_\_\_

## Signature:

Next Well Visit:  Per AAP Guidelines\* or  Age: \_\_\_\_\_

This child is healthy and may participate in all routine activities, sports, camps, and child care. 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 Number