GENERAL HEALTH APPRAISAL FORM

1-PARENT *Please complete, date and SIGN.*

Child's Name: _____ Birth Date: _____

Allergies: ___ None OR ___ List food/medication: _____
Diet: ___ Age appropriate ___ Special-Describe: _____
Skin Care: ___ Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

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

Michele DeSanti EMAIL: michele@kremmlingpreschool.org
Kremmling Preschool Director FAX: (970) 724-9052

_____ _____
Parent or Legal Guardian signature **Date**

2-HEALTH CARE PROVIDER *Please complete after parent section has been completed*

Date of most recent health appraisal: _____ Age: _____
Physical Exam: ___ Normal ___ Abnormal-describe: _____
Allergies: ___ None OR ___ List food/medication: _____ Type of Reaction: _____
Current Medications: ___ None OR ___ List: _____
A separate medication authorization form is required for medications given in school, childcare. To print form, go: https://drive.google.com/file/d/0B689O6uDomvTd0VWWWxIdkhVVERHUjlldWNtb01vVEpYQnc0/view
Current Diet: ___ Age appropriate ___ Special-describe: _____
A separate diet statement is required for food provided at school, child-care. To print form, go to: https://www.colorado.gov/pacific/sites/default/files/PF_CACFP_Special-Diet-Statement-Revised.pdf
Tuberculosis: ___ Not at risk OR Test Result: ___ Normal ___ Abnormal
Screens Performed:
___ Vision: ___ Normal ___ Abnormal ___ Hearing: ___ Normal ___ Abnormal
___ Oral Health: ___ Normal ___ Abnormal ___ Developmental: ___ ASQ ___ PEDS
___ Other: _____ Development Concerns: _____
Health Concerns: ___ Severe Allergies ___ Asthma ___ Seizures ___ Diabetes
___ Hospitalizations ___ Behavior Concerns ___ Developmental Delays ___ Vision
___ Hearing ___ Oral Health ___ Other: _____
Explain above concerns (if necessary, include instructions to care providers): _____
_____

PLEASE ATTACH A COPY OF CHILD'S IMMUNIZATION RECORDS TO THIS FORM. THIS IS MANDATORY. Thank you.

This child is healthy and may participate in all routine activities in school, childcare. Any concerns or exceptions are identified on this form.

_____ _____
Healthcare Provider PRINTED Name Phone

_____ _____
Signature of Healthcare Provider Date

OFFICE STAMP
Or write Address & Email