Teaching Tree
GENERAL HEALTH APPRASIAL FORM

Parent: please complete and sign

Child's Name_____Birthdate_____
Allergies: ☐ none ☐ yes, _____ Please describe type of reaction
_____
Diet: ☐ breast feed ☐ formula _____ ☐ table foods, age appropriate
☐ special diet, **please fill out appropriate special diet form**
Sleep: Your health care provider recommends that all infants less than 1 year be placed on their back for sleep.
Preventative: ☐ yes ☐ no Preventative 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 or school child care personnel to discuss my child's health concerns. My child's health provider may fax or email this form & applicable attachments to my child's school.
Parent Signature_____Date_____

Health Care Provider: please complete after parent section complete

Date of Health Appraisal: _____ Weight _____
Physical Exam: ☐ normal ☐ abnormal, specify_____
Allergies: ☐ none ☐ yes, describe/reaction_____
Significant Health Concerns: ☐ Severe Allergies ☐ Reactive Airway Disease ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Surgeries ☐ Developmental Delays ☐ Behavioral Concerns ☐ Vision ☐ Hearing ☐ Dental ☐ Nutrition ☐ Other _____
Explain any above concerns:_____
Current Medication: ☐ none ☐ yes, describe_____
Separate Medication Administration Form required for medications given at school.
Special Diet: ☐ none ☐ yes, describe _____
Separate Special Diet Form required.
Immunizations: ☐ up to date ☐ see attached ☐ administered today _____
Vision Screening: _____pass _____ refer to specialist
Hearing Screening: _____pass _____ refer to specialist
Date of last dental exam:_____
Next well visit: _____

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

Provider Signature _____ Date_____

Provider Printed Name_____

Name, address and phone or **Office Stamp**: