Please include Immunization Record.
Thank you, Kaela Chaffin
303-781-8900

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: Kaela Chaffin (Stepping Stones Academy) Fax: ______ Email: Kaela@ssamontessori.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

The form was created by the American Academy of Pediatrics, Colorado Chapter and Healthy Child Care Colorado to satisfy childcare and Head Start requirements in Colorado. While accepted by most schools, childcare programs and camps, this is not an official government form. Updated 01/2021.