

General Health Appraisal Form

Parent: Please complete

Child's Name: _____ Birthdate: _____

Allergies: ☐ None ☐ Describe: _____

Type of Reaction: _____

Diet: _____

☐ Special Diet: _____

☐ Preventive 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 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: 303-663-9763

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

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule

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COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ Date of Birth _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT - CERTIFICATE OF IMMUNIZATION

Vaccine	Enter the month, day and year each immunization was given
Hep B	Hepatitis B
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)
DT	Diphtheria, Tetanus (pediatric)
Tdap	Tetanus, Diphtheria, Pertussis
Td	Tetanus, Diphtheria
Hib	<i>Haemophilus influenzae</i> type b
IPV/OPV	Polio
PCV	Pneumococcal Conjugate
MMR	Measles, Mumps, Rubella
Varicella	Chickenpox

Healthcare Provider
Documentation Date

Lab Verification Date

Vaccines recorded below this line are recommended. Recording of dates is encouraged.

HPV	Human Papillomavirus
Rota	Rotavirus
WV4/MPSV4	Meningococcal
Hep A	Hepatitis A
TIV/LAIV	Influenza
Other	

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

A) Child Care Up to Date
Up to date through 6 months of age for Colorado School Immunization Requirements
Update Signature _____ Date _____

B) Child Care Up to Date
Up to date through 18 months of age for Colorado School Immunization Requirements
Update Signature _____ Date _____

C) Child Care/Pre-school/Pre-K*
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements
Update Signature _____ Date _____

D) Complete for K-5th Grade
Up to date for K-5th Grade for Colorado School Immunization Requirements
Update Signature _____ Date _____

If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption to the following vaccine(s):

La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption to the following vaccine(s):

Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption to the following vaccine(s):

Exención por creencias personales de la(s) siguiente(s) vacuna(s):

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)