HEALTH APPRAISAL FORM

Section 1 : TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name (Last) (First)	DOB	Date
Parent/Guardian Name	**Home Phone**	**Cell/Work Phone**

I give my consent for my child's Health Care Provider and Child Care Provider/School Administration to discuss the information on this form. I am aware that this is protected health information. **_____Yes _____No Signature/Date** _____

Section 2 : TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAM

Date of Physical Exam:	Results of Physical Exam normal? ____ Yes ____No
Essential Findings Deviating from Normal:	Weight:
	Height:
	Head Circumference (0 - 2yrs):
	Blood Pressure (3+ yrs):

IMMUNIZATIONS *(Please attach record)*

CHRONIC CONDITIONS	**COMMENTS** *(COMPLETE ATTACHED TREATMENT PLAN IF NEEDED TO KEEP CHILD SAFE AND HEALTHY IN SCHOOL OR DAYCARE)*
Chronic Medical Conditions/Related Surgeries • *List medical conditions/ongoing surgical concerns:*	
Medications/Treatments • *List medications/treatments:*	
Limitations to Physical Activity • *List limitations/special considerations:*	
Special Equipment Needs • *List items necessary for daily activities:*	
Allergies/Sensitivities • *List Allergies:*	
Special Diet/Vitamin & Mineral Supplements • *List dietary specifications:*	
Behavioral Issues/Mental Health Diagnosis • *List behavioral/mental health issues/concerns:*	

PREVENTIVE HEALTH SCREENINGS

TYPE SCREENING	DATE PERFORMED	STATUS	TYPE SCREENING	DATE PERFORMED	STATUS
Lead: ❍ Capillary ❍ Venous		❍ Normal ❍ In Care ❍ Referred	Hearing		❍ Normal ❍ In Care ❍ Referred
TB Status *(If applicable)*		❍ Normal ❍ In Care ❍ Referred	Vision		❍ Normal ❍ In Care ❍ Referred
Hgb/Hct		❍ Normal ❍ In Care ❍ Referred	Fluoride Varnish Provided		❍ Not Applicable
Other:		❍ Normal ❍ In Care ❍ Referred	Developmental ❍ Surveillance/Observation ❍ Validated Screening		❍ Normal ❍ In Care ❍ Referred

❍ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education unless noted above.***

Name of Health Care Provider *(Print)*_____ Practice _____

Signature/Date _____ Phone _____ Fax _____

TREATMENT ACTION PLAN

Section 3 : TO BE COMPLETED BY PARENT AND HEALTH CARE PROVIDER TOGETHER

❒ **ASTHMA** ❒ **ALLERGIES** ❒ **SEIZURES**

❒ **DIABETES** ❒ **OTHER** _____ ❒ **NOT APPLICABLE/NOT NEEDED**

Child's Name (Last) (First)	DOB
Doctor's Name	Date
Diagnosis	

RESCUE MEDICATION

❒ **NEEDED TO ATTEND SCHOOL** ❒ **SAFE TO ATTEND SCHOOL WITHOUT RESCUE MEDICATION**

MEDICATION NAME	**ROUTE** *(INHALER, NEBULIZER, ETC.)*	**DOSAGE**
1.		
2.		
3.		

Known Triggers:

Emergency Signs:

Plan for School:

Practice/Clinic _____ Phone _____

Signature _____ Date _____