

General Health Appraisal Form



Parent

Please complete, Date & 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*

Fax*

Email*


Drag your file(s) or [browse](#)

Date:

Parent/Guardian Signatures:

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:

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

General Health Appraisal Form



Health Care Provider

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule

Lead Level	<input type="checkbox"/>	Not at risk OR	<input type="checkbox"/>	Lead level	<input type="text"/>	TB	<input type="checkbox"/>	Not at risk OR Test Result	<input type="checkbox"/>	Normal	<input type="checkbox"/>				
Abnormal	<input type="checkbox"/>	Screens Performed	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>
Oral Health	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>	Developmental Screen	<input type="checkbox"/>	ASQ	<input type="checkbox"/>	PEDS	<input type="checkbox"/>	Other	<input type="text"/>		

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.



Drag your file(s) or [browse](#)


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 sitemap

Add your documents here, and you can upload up to 5 files max



Drag your file(s) to start uploading

OR

[Browse files](#)

Only support .jpg, .png and .svg and zip files

[Cancel](#) [Next](#)

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.