

# 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>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.</i> ____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 \_\_\_\_\_