

General Health Appraisal Form

Parent: Please complete

Child's Name: _____ Birthdate: _____

Allergies: None Describe: _____

Type of Reaction: _____

Diet: Breast Fed Formula: _____ Age Appropriate

Special Diet: _____

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

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: _____

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

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	Haemophilus influenzae type b
IPV/OPV	Polio
PCV	Pneumococcal Conjugate
MMR	Measles, Mumps, Rubella
Varicella	Chickenpox
Vaccines recorded below this line are recommended. Recording of dates is encouraged.	
HPV	Human Papillomavirus
Rota	Rotavirus
MCV4/MPSV4	Meningococcal
Hep A	Hepatitis A
TIV/LAIV	Influenza
Other	

Healthcare Provider Documentation Date _____ Lab Verification Date _____

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

Medical exemption to the following vaccine(s):

La exencion por razones medicas aplica a la(s) siguiente(s) vacuna(s):

Signed (Firma) _____ Date (Fecha) _____
Physician (Medico)

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.

EXENCION POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religion que se opone a la inmunizacion.

Religious exemption to the following vaccine(s):

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

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

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.

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

Personal exemption to the following vaccine(s):

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

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

Hep B DTaP Tdap Hib IPV PCV MMR VAR