GENERAL HEALTH APPRAISAL FORM

Return to BEEP upon completion by physician.
beeppreschool1@gmail.com

PARENT

Please complete, date, and 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:_____ _____

Parent/Guardian Signature:_____Date:_____

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: _____ Type of Reaction _____
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: _____

HEALTH CARE PROVIDER

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

Height: _____ B/P: _____ Head Circumference (up to 12 months): _____ HCT/HGB:_____
Lead Level: ☐ Not at risk OR ☐ Lead level: _____ TB: ☐ Not at risk OR Test Result: ☐ Normal ☐ Abnormal
Screens Performed: ☐ Vision: ☐ Normal ☐ Abnormal ☐ Hearing: ☐ Normal ☐ Abnormal
☐ Oral Health: ☐ Normal ☐ Abnormal Developmental Screen: ☐ ASQ ☐ PEDS ☐ Other: _____
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.

_____
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 STAMP

Or write Name, Address, Phone Number, Email

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.