GENERAL HEALTH APPRAISAL FORM

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.

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____