

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

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.
* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.
** Required by Head Start programs only per state EPSDT schedule.
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Health Care Plan

SEVERE ALLERGY TO: _____

Child's Name _____ Birth Date _____ Current Weight _____

School _____ Classroom/Grade _____

EMERGENCY TREATMENT

For Mild Symptoms

- Several hives
 - Itchy skin
 - Swelling at site of an insect sting
- OR if an ingestion (or sting) is suspected

Treatment:

1. Send child to health office ACCOMPANIED.
2. Give _____ of _____ by mouth.
dose (amount) antihistamine
3. Contact the parent or emergency contact person.
4. Stay with the student, keep student quiet, monitor symptoms until parent arrives.
Watch student for more serious symptoms listed below.

Special Instructions (for health care provider to complete):

Severe Symptoms can cause a *Life Threatening Reaction*

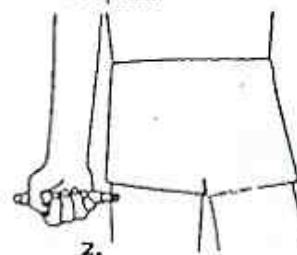
- Hives spreading over the body
- Wheezing, Difficulty swallowing or Breathing
- Swelling of face/neck, Tingling or swelling of tongue
- Vomiting
- Signs of Shock (extreme paleness/grey color, clammy skin)
- Loss of Consciousness.

Treatment:

1. Give EpiPen® or EpiPen Jr.® immediately, place against upper outer thigh, through clothing if necessary.
2. CALL 911 (or local emergency response team) immediately
EpiPen® only lasts 20-30 minutes
911 (emergency response team) should always be called if EpiPen® is given
3. Contact parents or emergency contact person.
If parents unavailable, school staff should accompany the child to the hospital.

Directions for use of EpiPen®:

1. Pull off grey cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, then remove.
5. Discard EpiPen® in impermeable can. Dispose per school policy, or give to emergency care responder. Do not return to holder.



Special Instructions (for health care provider to complete)

It is understood by the parent(s) and health care provider that this plan may be carried out by school personnel other than the school nurse. A Registered Nurse is to be responsible for delegation of this task to an unlicensed person.

Prescribing Practitioner Signature _____ Date _____

Parent/Guardian Signature _____ Date _____