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: ______________

______________________ Date: __________

Parent or Legal Guardian Signature — 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 ____________ (dose (amount)) of ____________ (antihistamine) by mouth.
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*

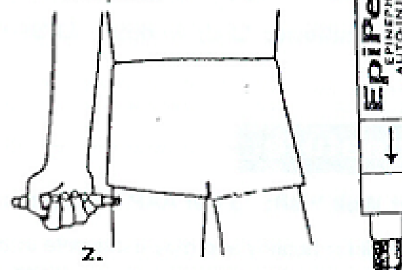
- **Hives spreading over the body**
- **Wheezing, Difficulty swallowing or Breathing**
- **Swelling of face/neck, Tingling or swelling of tongue**
- **Vomiting**
- **Signs of Shock (extreme paleness/grey color, clammy skin)**
- **Loss of Consciousness.**

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 ________