Fisher Early Learning Center: 1899 E. Evans Ave. Denver CO 80208: Ph. 303-871-2723: Fax 303-871-7805

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: Fisher Early Learning Center Fax: 303-871-7805 Email: tracy.dangelo@du.edu

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.

CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

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

Parent/guardian: _____

Required vaccines

	Each immunization date MM/DD/YY						Titer date
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							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella date of disease	
Varicella positive screen date	

Recommended vaccines

	Each immunization date MM/DD/YY					
HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider
I have reviewed this immunization record

Signature: _____ Date: _____

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT
I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____ Date: _____

Revised September 2016