



General Health Appraisal Form

Parent: *Please complete*

Child's name _____ Gender _____ Date of Birth _____

Address _____ Phone _____

Mother/ Guardian Name _____ Father/ Guardian Name _____

Allergies _____

Drug Reactions _____

Illnesses (Check illnesses the child has had and give approximate dates)

Chicken Pox _____ Rubeola _____ Asthma _____

Mumps _____ Rubella _____ Epilepsy _____

Polio _____ Rheumatic Fever _____ Diabetes _____

Strep Throat _____ Whooping Cough _____ Other _____

Surgeries/ Accidents/ Chronic or Disability Conditions _____

Describe any **special requirements** for which your child may need assistance from preschool staff: _____

Immunizations up to date: Yes ___ No ___ (Copy of records must be given to the preschool **before** child may attend.)

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: _____ Recent Height: _____

Physical Exam: Normal _____ Abnormal: _____ (see explanation of significant health concerns:)

Significant Health Concerns: None _____

Describe any **physical condition** requiring special attention by the preschool staff _____

If tuberculin test given: Date _____ Result: _____ If chest x-ray given: Date _____ Result: _____

Current Medications/ Special Diet: ___ None ___ Describe: _____

(Separate medication authorization form required for medications given at school.)

Signature: *Licensed Physician or Nurse Practitioner*

Date of Next Well Visit: _____

This child's health status allows participation in all preschool activities. Any concerns or exceptions are identified on this form.

Date _____

Signature of Health Care Provider (certifying form was reviewed.)

Office Stamp: *name, address, phone #*

Blank area for Office Stamp