

**Colorado School for the Deaf and the Blind
Early Education Center
Preschool Programs
Preschool Physical/General Health Appraisal Form**

Parent: Please Complete Top Section

Child's Name: _____ Birthdate: _____

Allergies: None Yes, Describe: _____

Type of Reaction: _____

Diet: Breast Feed Formula: _____ Age Appropriate

Special Diet: _____

Preventative 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 my 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 Filled Out Above

Date of Last Exam: _____ Recent Weight: _____ **HCT: _____ **B/P: _____ **Lead Level: _____

Physical Exam: Normal Abnormal (*please complete a full physical and explanation if it is abnormal*):

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)

Immunizations: Up-to-date See attached immunization record Administered today: _____

Health Care Provider Signature and Office Information

Signature of Health Care Provider (certifying form was reviewed)

Date

Office Information