**General Health Appraisal Form**

Portions of this report are to be filled out by a health care professional who has seen the child in the last twelve months.

Name of Facility: **Riverhouse Children’s Center** (Fax: 970-247-5355)

**To be filled out by Parent**:

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give consent for my child’s health provider to discuss my child’s health concerns with appropriate school personnel. Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be filled out by Health Care Provider:**

Past Illnesses - Check those that the child has had and give approximate dates:

Chicken Pox: \_\_\_\_\_\_\_ Roseola: \_\_\_\_\_\_\_ Rubella: \_\_\_\_\_\_\_

Rheumatic Fever: \_\_\_\_\_\_\_ Asthma: \_\_\_\_\_\_\_ Hay Fever: \_\_\_\_\_\_\_

Diabetes: \_\_\_\_\_\_\_ Mumps: \_\_\_\_\_\_\_ Epilepsy: \_\_\_\_\_\_\_

Whooping Cough: \_\_\_\_\_\_\_ Poliomyelitis: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery/Accidents/Illnesses/Chronic Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any physical condition requiring the facilities special attention: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication(s) Prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If tuberculin test given: Date: \_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_

If chest x-ray given: Date: \_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_

Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please record immunizations and dates administered on the Colorado Dept. of Health Certificate of Immunization SCHOOL FORM and attach.\***

Date of my most recent examination of this child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of licensed Physician or other health care professional Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Phone