Smiling Faces Academy, LLC

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child’s health care provider may mail or email this form to Smiling Faces Academy .

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight @ Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Exam: \_\_\_\_ Normal \_\_\_\_\_ Abnormal (Specify any physical abnormalities)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_ None or Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Health Concerns: \_\_\_Severe Allergies \_\_\_Reactive Airway Disease \_\_\_Asthma \_\_\_Seizures \_\_\_Diabetes \_\_\_Hospitalizations\_\_\_Developmental Delays \_\_\_Behavior Concerns\_\_\_Vision\_\_\_Hearing \_\_\_Dental \_\_\_Nutrition \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain above concern (if necessary, include instructions to care providers): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications/Special Diet: \_\_\_\_None or Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Separate medication authorization form is required for medications given in school

Immunizations: \_\_\_Up-to-Date \_\_\_ See attached immunization record \_\_\_Administered today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This child is healthy and may participate in all routine activities in school sports or school program. 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, #

Smiling Faces Academy 1430 A Nelson Road Longmont. CO 80501

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