**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:

 Date:

Parent or Legal Guardian Signature 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*