Physical Exam for General Health Appraisal

PARENT: Please complete and sign

Child's name: _____ Birthdate: _____

Allergies: None ___ Describe/list allergies_____

Type of allergic reaction _____

Diet: Age appropriate _____ Special diet _____

I give consent for my child's health provider, school or camp personnel to discuss my child's health concerns.

Parent/guardian signature: _____ Date: _____

This form may be faxed to the CHC Clinic 303-325-8132.

HEALTH CARE PROVIDER: Please complete and sign

Date of last exam: (expires in 365 days) _____ Weight at exam: _____

Physical Exam was: Normal _____ Abnormal _____

Allergies: None _____ Describe/list with reactions _____

Significant Health Concerns: Severe Allergies _____ Asthma/Reactive Airway Disease _____ Seizures _____ Diabetes _____

Developmental _____ Behavior _____ Hospitalizations _____Hearing _____ Vision _____ Dental _____ Nutrition _____

Explain concerns _____

Medications given at school/special diet: _____

PROVIDER SIGNATURE:

OFFICE STAMP: Or write Name, Address, Phone

Next Well Visit: Per AAP guidelines _____ or Age _____

This child is healthy and may participate in all routine activities in school sports, child care and camp programs.

Any concerns or exceptions are noted above.

_____ Date: _____

Signature of Health Care Provider (certifying was reviewed)