

Aurora Public Schools Early Childhood Education



2017-18

Well Child Exam

General Health Appraisal

**TO BE COMPLETED BY HEALTH CARE PROVIDER
PARA SER LLENADO POR EL MEDICO**



Parents/ Guardian: After this form has been completed by your healthcare provider please take it to your child's attending school. Meadowood CDC Nurse Fax # (303)326-3852

Padres/Guardianes: Después de que esta forma se llenada por el médico por favor de llevarla a la escuela donde atiende su niño(a).

Child's Name: _____ **Birthdate:** _____

Allergies: None or Describe _____
 Type of Reaction _____

Diet: Breast Fed Formula _____ Age Appropriate

Special Diet _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.
 Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ DATE: _____

Parent/Guardian Signature _____

A new Well Child Exam and newly dated form must be submitted every 12 months.

Date of Last Well Child Exam expires after 12 calendar months.

Date of Last Well Child Exam: _____ **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, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed
 Dose _____ or see the attached age-appropriate dosage schedule from our office

OR Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed
 Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: Up-to-Date See attached immunization record Administered today:

Health Care Provider: Must Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

** Height @ Exam _____ ** B/P _____ ** Head Circumference (up to 12 months) _____ **

** HCT/HGB _____ ** Lead Level Not at risk or Level _____

** TB Not at risk or Test Results Normal Abnormal

** Screenings Performed: Vision: Normal Abnormal Hearing: Normal Abnormal Dental: Normal Abnormal Recommended

Follow-up _____

Health Care Provider Signature

Next Well Visit: Per AAP guidelines* or Age _____

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

*The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/17
 *The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.
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