

GENERAL HEALTH APPRAISAL FORM

PARENTS, PLEASE COMPLETE AND SIGN:

Child's Name: _____ Birthdate: _____

Allergies: None Please describe: _____ Type of reaction: _____

Special Diet: _____

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 health care provider to discuss my child's health concerns. My child's health care provider may fax this form (and applicable attachments) to Rivendell School.

Health Care Provider Name: _____ Phone # _____ Fax # _____

Parent/Guardian Signature _____ Date: _____

HEALTH CARE PROVIDER, PLEASE COMPLETE AFTER THE PARENT SECTION IS COMPLETED:

Date of Last Health Appraisal: _____ Weight at Exam: _____

Physical Exam: Normal Abnormal (specify any physical abnormalities) _____

Allergies: None or describe _____ Type of reaction _____

Significant Health Concerns: Severe Allergies Reactive Airway Disease or 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 at school****

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 four hours as needed.

Dose _____ (Please do NOT attach dosage schedule - MUST be filled out by health care provider).

OR **Ibuprofen** (Motrin, Advil) may be given for pain or for fever over 102 degrees every six hours as needed.

Dose _____ (Please do NOT attach dosage schedule - MUST be filled out by health care provider).

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 programs. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider Date
(certifying form was reviewed)

*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.

OFFICE STAMP (or write name, address and phone number)

****REMINDER: Rivendell School will need a current Certificate of Immunizations or Exemptions Form on file.****

Please return this form to: Rivendell School
1800 East Prospect Road, Fort Collins, CO 80525; office@Rivendell-School.org
(970) 493-9052 (phone) (970) 493-9056 (fax)

