

**GENERAL HEALTH APPRAISAL FORM**

Please have physician complete, sign, and date this form within 30 days of enrollment.

Tenderfoot Child & Family Development Center  
700 North Colorado Street  
Gunnison, CO 81230 | tfootdirector@gmail.com

**PARENT: please complete**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Allergies:  None  Describe: \_\_\_\_\_

Type of Reaction: \_\_\_\_\_

Diet:  Breast Fed  Formula: \_\_\_\_\_  Age Appropriate

Special Diet: \_\_\_\_\_

**Screenings: please check the types of screenings your child has had in the past year**

Vision Screening Date \_\_\_\_\_ Location \_\_\_\_\_

Hearing Screening Date \_\_\_\_\_ Location \_\_\_\_\_

Dental Screening Date \_\_\_\_\_ Location \_\_\_\_\_

Preventive 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 consent for my child's health provider and child care provider to discuss my child's health concerns. My child's health provider may forward this form (and applicable attachments) to Tenderfoot Child & Family Development Center.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date Authorization Expires 365 days from this date

**Health Care Provider: please complete after parent section is complete**

Date of Last Exam: \_\_\_\_\_ Recent Weight: \_\_\_\_\_ \*\*HCT: \_\_\_\_\_ \*\* B/P: \_\_\_\_\_ \*\*Lead Level: \_\_\_\_\_

Physical Exam:  Normal  Abnormal (see explanation of significant health concerns:)

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: \_\_\_\_\_

Immunizations:  Up-to-date  See attached immunization record  Administered today: \_\_\_\_\_

Next Well Visit:  Per AAP Guidelines\* or  Age: \_\_\_\_\_

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider: \_\_\_\_\_

Certifying the form was reviewed

**Office Stamp: or write name, address, phone number**

\* 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