General Health Appraisal Form

Parent: *Please complete*

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

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

Diet: ❑ Breast Fed ❑ Formula: _____ ❑ Age Appropriate

❑ Special Diet: _____

❑ **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, 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 completed*

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: _____

_____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

Immunizations: ❑ Up-to-date ❑ See attached immunization record ❑ Administered today: _____

_____

Signature:

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 form was reviewed) — Date

Office Stamp: *Or write Name, Address, Phone Number*

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* 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.

** Required by Head Start programs only per state EPSDT schedule

SAMPLE

MEDIA USE PERMISSION FORM*

Child's Name: _____ **Age:** _____

I do/do not give permission for my child to use or view the following:

	YES	NO
Television Viewing	____	____
Video Viewing	____	____
Music	____	____
Video Games	____	____
Computer Use	____	____
Other: _____	____	____

My child may engage in the approved activities for up to _____ total hours per day.

* Regulations for facilities caring for children require that media use is permitted only with the written approval of a child's parent or guardian, including appropriate time limits.

These activities must not contain violence, profanity, nudity, sexual, or inappropriate content.

All children must be provided with an alternative activity once the child/children lose interest in the media activity.

Signature of Parent or Guardian: _____ **Date:** _____

CHILD PICK UP INFORMATION

Persons authorized to pick up your child
(Must show photo ID)

Name_____

Home Phone _____ Work Phone_____

Name_____

Home Phone _____ Work Phone_____

Name_____

Home Phone _____ Work Phone_____

Name, address and phone number of child's doctor _____
_____

Name, address and phone of child's dentist _____
_____

Hospital of Preference (Please check one)

☐ The Children's Hospital
13123 East 16th Avenue
Aurora, CO 80045
720-777-1234

☐ Insert Nearest Local Hospital

☐ Insert Nearest Local Kaiser Permanente Hospital

☐ Other_____
_____
_____
_____

Chronic Medial conditions _____

Does your child have a health care plan ? _____ If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized ? _____ Completed immunization records must be provided on or before the first day the child is in care.

Food Allergies _____

TOPICAL PREPARATIONS (PREVENTIVE) PERMISSION FORM

This form covers a variety of preventive topical preparations that may be applied to the skin with parent/guardian permission

Child's Name _____ Parent/Guardian's Name: _____

SUNSCREEN

I give my permission for the staff at _____ to assist with applying or apply sunscreen to my child's exposed skin including the face, tops of ears and bare shoulders, arms, legs and feet 30 minutes before outdoor activities. It is my responsibility to provide sunscreen with a minimum SPF of 15. I understand I must provide the sunscreen in its original container labeled with my child's name and within the noted expiration date. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- ☐ In the event that my child does not have sunscreen with them, the school may apply _____ to my child. It is my responsibility to check the ingredients of this product to ensure my child is not allergic to it.
  Name of Sunscreen & SPF
- ☐ My child may NOT use any sunscreen other than the one that he/she brings.

Parent/Guardian Signature: _____ Date: _____

MOISTURIZING LOTION/CREAM/BALM

I give my permission for the staff at _____ to assist with applying or apply skin lotion/cream to my child. I understand I must provide the lotion/cream/balm in the original over the counter container labeled with my child's name. It is my responsibility to check the ingredients of this product to ensure my child is not allergic to it. Skin lotion/cream/balm will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- ☐ Name of product: _____
  Special instructions: _____
- ☐ My child may NOT use any other skin lotion/cream/balm than the one he or she brings

Parent/Guardian Signature: _____ Date: _____

DIAPER OINTMENT/CREAM

I give my permission for the staff at _____ to apply over the counter diaper rash ointment/cream to my child. I understand that I may only provide diaper ointment or cream, free of antibiotic, antifungal or anti-inflammatory components without a written prescription from my doctor. I understand I must provide the ointment/cream in the original over the counter container labeled with my child's name. Ointment/cream will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- ☐ Name of product: _____
  Special instructions: _____
- ☐ My child may NOT use any other diaper ointment/cream than the one he or she brings

Parent/Guardian Signature: _____ Date: _____

The Children's Hospital
School Health Program
Aurora, CO 303.281.2790
2009

SAMPLE CHILDREN'S ENROLLMENT RECORD

Date of Enrollment_____

Child's Name _____ **Nickname**_____

Home Address _____

Home Phone _____ **Sex M F Age** _____ **Date of Birth**_____

Family Members: _____

Mother or Guardian's Name _____

Address if different from child's _____

Zip_____ **Home Phone**_____ **Cell Phone**_____ **Email** _____

Name of employment (mother/guardian)_____

Address of employment (mother/guardian)_____ **Work Phone**_____

Father or Guardian's Name _____

Address if different from child's _____

Zip_____ **Home Phone**_____ **Cell Phone** _____ **Email** _____

Name of employment (fatherguardian)_____

Address of employment (father/guardian)_____ **Work Phone**_____

Special instructions for reaching parent or guardian _____

EMERGENCY CONTACTS

1. Name_____ **Home Phone** _____

Address_____

Work Phone_____ **Relationship to child**_____

2. Name _____ **Home Phone**_____

Address_____

Work Phone _____ **Relationship to child**_____

To be filled out annually

HEALTH HISTORY
(Chronic or recurring)
Ear Infections _____
Diabetes_____
Heart disease/defect_____
Convulsion/seizures_____
Asthma _____
Nosebleeds_____
Measles_____
Mumps_____
Chicken Pox _____
Flu or Flu shot _____

ALLERGIES
(Nature of Reaction)
Hay Fever_____
Plant Poisoning_____
Insect stings_____
Penicillin_____
Other drugs_____
Animals_____
Food_____
Other_____

Operations or serious injuries (dates)_____

Is the child on any medications? (Explain)_____

If yes, please describe_____

Physical limitations_____Describe if yes_____

Dietary limitations_____Describe if yes_____

Vision _____Hearing_____

Are there any activities that you prefer that your child NOT participate in?

If so please list: _____

Authorization for Emergency Medical Care

I hereby give my permission to _____ to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

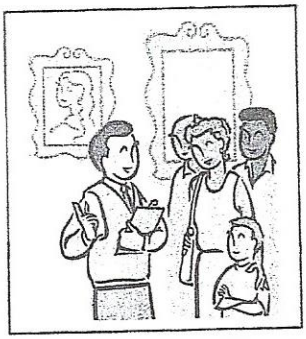
Parent/Guardian signatures

_____Date _____

_____Date_____

Adventures in Bethel

WALK TO THE PARK PERMISSION FORM



Your child's will be walking to the neighborhood park few times a week if weather permits.

Location:	1.5 blocks away

Please return this permission slip by the first day of care.

I give permission for my child, _____, to walk to the park during attending Adventures in Bethel.

In case of an emergency, I give permission for my child to receive medical treatment. In case of such an emergency, please contact:

_____ _____

(Name) *(Phone Number)*

_____ _____

(Parent/Guardian Signature) *(Date)*

Family Interview Form

Child's name:_____ Date of birth _____ Sex:_____

Nickname(s) child responds to:_____

Date of admission: _____ Age: _____

Adult interviewed: _____ Relationship to child _____

Interviewed by:_____ Date: _____

1. Reason for choosing childcare for your child:

   _____

2. Family relationships:

   A. Who are the primary caregivers of the child? (These would be people who have significant contact/influence with your child and/or may participate in the care of your child.) Do they live with you? What are their other responsibilities in the family (including work, school and other responsibilities)?

   _____

   B. Relationships with brothers, sisters, and other children:

Name of child(ren)	*Age*	*Living with the child?*

   C. Relationships with others living in the home:

Name	*Age*	*Relationship to child*	*Does the person take care of the child? How often?*

3. Communication:

   A. What is the primary language spoken in the home?

   _____

   B. How does your child communicate his/her needs?

   _____

4. Diapering and toileting

   A. What is your child's diapering or toileting routine?

   _____

HANDOUT

Understanding and Respecting the Gifts of Culture

B. What words does your child use for urination? _____

Bowel movements? _____

C. If your child is using the toilet, please describe how you know when s/he needs to use it, and what assistance you usually provide:

_____

_____

_____

5. Eating:

A. What is an everyday feeding time or mealtime like in your home?

_____

B. Does your child have any dietary restrictions or food allergies?

_____

C. What are your child's favorite foods? Does s/he have any strong food dislikes?

_____

6. Sleeping:

A. How does your child nap at home?

_____

B. How does your child show that s/he is tired?

_____

C. Does your child have a special routine before going to sleep?

_____

D. Does your child have a special object (lovey or cuddly) that s/he sleeps with or uses for comfort?

_____

E. If there are problems concerning sleeping, do you have any special way of handling them?

_____

F. Is your child fairly regular in his/her sleeping habits (i.e. time of day; length of nap)?

_____

7. Development of feelings:

   A. How does your child like to be comforted?

   _____

   B. Does your child use a pacifier? Do you have any rules about its use?

   _____

   C. How does your child usually react to being separated from the people who will be dropping him/her off?

   _____

   D. Are there things your child is afraid of (i.e. dogs; loud noises)?

   _____

   E. How does s/he express anger, or react to frustration?

   _____

   F. How does s/he express feelings of pleasure, excitement, or joy?

   _____

   G. What do you do when your child does something you think is wrong or bad for your child, or when your child does not listen to you?

   _____

   H. Do any of your child's behaviors cause you concern?

   _____

8. What are your child's interests? What does s/he enjoy doing?

   _____

9. In a few sentences, how would you describe your child?

   _____

10. What would you like your child to be like when s/he is an adult?

    _____

11. Are there any holidays or special occasions that you would like to celebrate with your child?

    _____

12. Is there any other special information that we should know to serve your child better?

    _____