

## General Health Appraisal for Enrollment in Child Care

(To be completed by the Health Care Professional)

Date of Physical Examination: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Health History & Medical Information** pertinent to routine child care & emergencies, please describe:

Allergies (indicate type): \_\_\_\_\_ Drug reactions: \_\_\_\_\_

Type of Reaction to allergen: \_\_\_\_\_

Severity and Treatment of allergy: \_\_\_\_\_

Contact with tuberculosis: Yes \_\_\_\_\_ No \_\_\_\_\_ If tuberculin test given: Date \_\_\_\_\_ Result \_\_\_\_\_

If chest x-rayed: Date \_\_\_\_\_ Result \_\_\_\_\_

Has child had chicken pox? Yes \_\_\_\_\_ No \_\_\_\_\_

**Describe any recurrent health issues** (asthma, seizures, ear infections, hospitalizations, developmental concerns, medications required):

\_\_\_\_\_  
\_\_\_\_\_

**Physical findings, comments and recommendations to preschool personnel:**

Acetaminophen \_\_\_\_\_ may be given for fever over 101 or every 4 hours as needed.  
Amount

**PLEASE ATTACH A COPY OF CHILD'S IMMUNIZATION RECORDS TO THIS FORM. THIS IS MANDATORY.** Thank you.

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

I \_\_\_\_\_ give consent for my child's health care provider  
(Name of parent/legal guardian)  
& child care provider to discuss my child's health concerns. Please list other family members  
who may have access to your child's health information on file: \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian signature

\_\_\_\_\_  
Date