

**General Health Appraisal (0-2 years) for enrollment in Child Care**  
(To be Completed by a Health Care Professional)

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

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

\_\_\_\_ None  
\_\_\_\_ Yes (Please describe):

Nutrition: \_\_\_\_\_ Special diet: \_\_\_\_\_

Allergies: \_\_\_\_\_ Type of reaction: \_\_\_\_\_

Current medications: \_\_\_\_\_

Acetaminophen(Tylenol) \_\_\_\_\_ may be given for fever over 102°F or pain every 4 hours as needed (Note: Nore more than a 3 day period, without medical authorization)

Describe any recurrent health problem (such as asthma, seizures, ear infections, diabetes, etc.) illness, hospitalization, or concerns with development.

\_\_\_\_ None                      \_\_\_\_ Please describe

\_\_\_\_\_

Comments: (include instructions to the child card providers(s))

\_\_\_\_\_

Date of most recent examination of child (within the last 12 months): \_\_\_\_\_

Weight \_\_\_\_\_ Height: \_\_\_\_\_

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_ Dental Screening: \_\_\_\_\_

Health Appraisal Plan (check visit which apply)

\_\_\_\_ 2 month    \_\_\_\_ 4 month    \_\_\_\_ 6 month    \_\_\_\_ 9 month    \_\_\_\_ 12 month    \_\_\_\_ 15 month

\_\_\_\_ 18 month    \_\_\_\_ 24 month    \_\_\_\_ other (please specify) \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I \_\_\_\_\_ give consent for my child's health care provider and child care provider to discuss my child's health concerns.

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_