



General Health Appraisal Form

PARENT: Please complete and sign

Child's Name: _____ Birthdate: _____

I, _____ give consent for my child's care health provider, school, childcare, or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, or childcare personnel to SkyView Academy at FAX #: (303) 470-1903

Parent/Guardian Signature _____ DATE: _____

HEALTH CARE PROVIDER: Please complete and sign

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

Physical Exam: Normal OR Abnormal (Specify any physical abnormalities) _____

Significant Health Concerns: Severe Allergies/ Reactive Airway Disease/Asthma; Seizures/Diabetes/Hospitalizations;

Allergies: Describe: _____

Type of Reaction: _____

EpiPen required (Requires Severe Allergy Health Care Plan*)

Medication required (Requires Severe Allergy Health Care Plan and Permission to Administer Medication*): _____

Other developmental delays, behavior concerns, vision, hearing, dental, nutrition: _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: Describe _____

Separate *Permission to Administering Medications Form* is required for medications given in school, child care or camp*

Immunizations up to date (Please attach current record)

Screenings Performed: Vision: Normal/Abnormal Hearing: Normal/Abnormal

Dental: Normal/Abnormal

Recommended Follow-up _____

Date of next well visit: _____

Practice Name/Address/Phone/Dr. _____

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

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

**Please request these forms at SkyView office*

Please return this form via fax at (303) 470-1903 or call (303) 471-8439 with any questions.