General Health Appraisal Form

Bookcliff Christian School

2702 Patterson Rd. Grand Junction, CO 81506 / 970-243-2999 / school@bookcliffbaptist.org/ fax 549-0165

Parent: *Please Complete*

Child's Name: ________________________________ **Birthdate:** ________________

Report of General Health: ____

____

Does Child have: (*Check any that apply)*

___Frequent colds ___Frequent sore throat ___Bronchitis ___Sinusitis

___Allergies ___Asthma ___Kidney Disease ___Heart disease

___Convulsions ___Stomach Upsets ___Vision Deficiency ___Glasses/Contacts

___Hearing Deficiency ___Other ______________________________

Explain any conditions marked____

____

Preventative creams/ointments/sunscreen may be applied as requested in writing by parent.

I, ____ give consent for my child's health provider or school to discuss my child's health concerns. My child's health provider may return this form (and applicable attachments) to my child's childcare provider or school.

____ 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:**______________

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 concerns above (if necessary, include instructions to childcare providers/teachers):____________

____

Current Medications/Special Diet: ____None ____Describe:_________________________________

____

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

Is there any reason why the student cannot participate in a full physical education program? _____ If yes, explain____

____

Health Care Provider Signature:

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.

____ Date ________________________________

***Signature of Health Care Provider**
(certifying form was reviewed)

****Attach Copy of Immunization record****