General Health Appraisal and Permission
Bookcliff Christian School

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

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_____
_____

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 the 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****