

**Adams County Head Start**  
General Health Appraisal Form

**Parent(s) – Please complete:**

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

**Allergies:**  No  Yes: \_\_\_\_\_  
Type of Reaction: \_\_\_\_\_

**Health Concerns:**  No  Yes  
Explain: \_\_\_\_\_

**Diet:**  Age Appropriate  Special Diet: \_\_\_\_\_

I, \_\_\_\_\_, give consent for my child's health provider to discuss my child's health concerns with Adams County Head Start health personnel. My child's health provider may fax this form and applicable attachments to Adams County Head Start.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date (Authorization expires 365 days after this date.)

**Health Care Provider – Please complete all information below:**

**Physical Exam Date:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **BMI:** \_\_\_\_\_

**Lead and Anemia Screenings REQUIRED for Head Start**

**Lead Date:** \_\_\_\_\_ **Result:** \_\_\_\_\_ **Hgb/Hct Date:** \_\_\_\_\_ **Result:** \_\_\_\_\_  
(Needed Annually)

**Physical Exam:**  All Within Normal Limits  Exceptions to Normal Exam Noted Below  
**Health Concerns:**  None  Asthma  Seizures  Diabetes  Developmental Delays  
 Diet/Nutrition  Vision  Hearing  Hospitalizations  Dental  
 Severe Allergies  Other: \_\_\_\_\_

**Explain above concerns, including instructions to child care provider(s):** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Immunizations:**  Child is up-to-date  Child has all immunizations possible at this time  Exemption

**Immunizations due (if needed):** \_\_\_\_\_

**\*\*PROVIDER, PLEASE INCLUDE MOST RECENT COPY OF CHILD'S IMMUNIZATION RECORD.\*\***

**Signature:**

**Next Well Visit:** per AAP Guidelines or Age \_\_\_\_\_

This child is healthy and may participate in all routines, activities, sports, camps, and child care. Any concerns and/or exceptions are identified on this form.

\_\_\_\_\_  
Signature of Health Care Provider certifying form was reviewed

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

**Office Stamp:**

If no stamp, please include:

**Clinic Name:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_