Reset

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General Health Appraisal Form (Birth – 5 Years)

To Parent/Guardian: In order to provide a quality experience for your child, our care providers must understand each child's health needs. This form asks for information from families, as well as information from your health care professional.

Please Note: Current Health Appraisals are required upon enrollment and every 3 months for children 0-24 months and then annually from 2-6 years. Current immunization records are also required.

Childs Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian Name: _____ Mobile Phone: _____

Primary Health Care Provider: _____

Name of Dentist: _____

Health Insurance Company: _____

Policy/Plan/Medicaid Number: _____

Does your child have health insurance? ☐ Y ☐ N

Does your child have dental insurance? ☐ Y ☐ N

Has your child had the following developmental screenings?

Hearing ☐ Y ☐ N

Vision ☐ Y ☐ N

Dental ☐ Y ☐ N

The Children's Center provides information on access to developmental screening in the Family Handbook available at:
https://www.denverathleticclub.cc/child-care

For more information, please contact The Children's Center at (720) 931-6725.

Part I – To be completed by Parent/Guardian

Any health concerns?	☐ Y	☐ N	Frequent ear infections?	☐ Y	☐ N
Allergies to food, bee stings, insects?	☐ Y	☐ N	Any speech issues?	☐ Y	☐ N
Allergies to medication?	☐ Y	☐ N	Any problems with teeth?	☐ Y	☐ N
Any other allergies?	☐ Y	☐ N	Has your child had a dental exam?	☐ Y	☐ N
Any daily/ongoing medications?	☐ Y	☐ N	When:_____		
Any problems with vision?	☐ Y	☐ N	Very high or low activity level?	☐ Y	☐ N
Any hearing concerns?	☐ Y	☐ N	Weight concerns?	☐ Y	☐ N
Asthma treatment?	☐ Y	☐ N	Problems breathing or coughing	☐ Y	☐ N
Seizures?	☐ Y	☐ N	**Developmental – Any concerns about your child's:**		
Diabetes?	☐ Y	☐ N	1. Physical development?	☐ Y	☐ N
Any heart problems?	☐ Y	☐ N	2. Movement from one place to another?	☐ Y	☐ N
Emergency Room visits?	☐ Y	☐ N	3. Social development?	☐ Y	☐ N
Any major illness or injury?	☐ Y	☐ N	4. Emotional development?	☐ Y	☐ N
Any operations/surgeries?	☐ Y	☐ N	5. Ability to communicate needs?	☐ Y	☐ N
Sleeping concerns?	☐ Y	☐ N	6. Interaction with others?	☐ Y	☐ N
Eating concerns?	☐ Y	☐ N	7. Behavior?	☐ Y	☐ N
Toileting concerns?	☐ Y	☐ N	8. Ability to understand?	☐ Y	☐ N
Birth to 3 services?	☐ Y	☐ N	9. Ability to use hands?	☐ Y	☐ N

Have you talked with your primary health care provider about any of these concerns? ☐ Y ☐ N

Please explain all "Yes" answers and provide additional information. You may attach additional pages if necessary.

Please list any medications your child will need to take during program hours:

I _____ give consent for my child's health care provider and child care provider to
Parent/Guardian Name (Please Print)
discuss my child's health concerns.

_____ _____

Parent/Guardian Signature Date