

CONCORDIA LUTHERAN SCHOOL MEDICAL FORM
GENERAL HEALTH APPRAISAL (2-12 years) FOR ENROLLMENT IN CHILD CARE

To be completed by The Health Care Professional (Please print.)

Child's Name: _____ Birthdate: _____

Date of most recent examination: _____ (Note: within the last 12 months)

Weight _____ Height _____

Health History and Medical Information pertinent to routine child care and emergencies:

Special diet _____

Allergies _____ Type of reaction _____

Current Medications _____

Comments: (include instructions to the child care providers) _____

_____ Health Care Plan attached

Is there any condition that would limit participation in our program? _____

Please describe any recurrent health problem (such as asthma, seizures, ear infections, diabetes, etc.) illness, hospitalization or concerns with development: _____ None

Comment on any significant findings:

Vision: _____ Hearing: _____ Speech: _____

Surgeries: _____

Serious Injuries: _____

Health Care Provider Name (please print)

Signature of Health Care Provider

Date

Address _____ Phone _____

I _____ give consent for my child's health care provider and child care provider to discuss my child's health concerns.

Parent or legal guardian signature

Date

CONCORDIA LUTHERAN SCHOOL
13371 W. ALAMEDA PKWY.
LAKEWOOD, CO 80228
PHONE 303-989-5260 FX 303-988-3136

(over)

HEALTH HISTORY

To be completed by Parent or Guardian and returned to preschool before the first day of class.

General evaluation of family's health:

Family deaths (causes):

Child's illnesses: If your child has had any of these diseases, please state the age at which he/she had them.

- | | |
|---|--|
| <input type="checkbox"/> measles | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> mumps | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> whooping cough | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> asthma | |

Please check any of the following which you have noticed.

- | | |
|---|--|
| <input type="checkbox"/> frequent sore throat | <input type="checkbox"/> persistent cough |
| <input type="checkbox"/> frequent nose bleed | <input type="checkbox"/> frequent headache |
| <input type="checkbox"/> frequent urination | <input type="checkbox"/> speech difficulty |
| <input type="checkbox"/> tires easily | <input type="checkbox"/> four or more colds per year |
| <input type="checkbox"/> poor vision | <input type="checkbox"/> hard of hearing |

Describe your child socially and emotionally:

Signature of Parent or Guardian

Date

(over)