



GILPIN COUNTY PRESCHOOL

"Home of the Eagles"

General Health Appraisal

(To be completed by the Health Care Provider)

Child's Name: _____ Date of Birth: _____

Health History and Medical Information:

_____ None
_____ Describe

Special Diet: _____

Allergies: _____ Type of reaction: _____

Current Medication (s): _____

Any Medication required to be given at school: _____

Describe any recurrent health problems (such as asthma, seizures, ear infections, diabetes, etc), illness, hospitalizations or concerns with development:

Comments (include instructions for preschool staff): _____

Date of most recent examination: _____

Weight: _____ Height: _____

Vision: _____ Hearing: _____

Dental Screening: _____

Health Provider Name: _____

Health Provider Signature: _____ Date: _____

Phone: _____ Fax: _____

Address: _____

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

Parent or Guardian Signature

Date