

Physician's Health Form

Parent: Please complete

Child's Name: _____ **Birthdate:** _____

Allergies: None Describe: _____

Type of Reaction: _____

Diet: Breast Fed Formula: _____ Age Appropriate

Special Diet: _____

Preventative creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

Parent or Legal Guardian Signature Date: _____
Authorization expires 365 days after this date

Health Care Provider: Please complete after parent section has been completed

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ ****B/P:** _____ ****Lead Level:** _____

Physical Exam: Normal Abnormal (see explanation of significant health concerns.)

Significant Health Concerns: None Reactive Airways Disease Seizures Diabetes Development Delays

Vision Hearing Hospitalizations Severe Allergies Other (dental, nutrition, behavior, etc) _____

Explain above concerns (if necessary, include instruction to childcare providers): _____

Current Medications/Special Diet: None Describe: _____

(Separate medication authorization form required for medications given in Child care)

Fever reducer or pain reliever (mark only one product: max. 3 consecutive days without additional medical authorization)

Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:

Dose _____ See attached Dosage Schedule from our office

OR

Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:

Dose _____ See attached Dosage Schedule from our office

Immunizations: Up-to-date See attached Immunization record Administered today: _____

Signature:

Next Well Visit: Per AAP Guidelines* or Age: _____

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

Signature of Health Care Provider (certifying form was reviewed) Date

Office Stamp:

Or write Name, Address, Phone Number.