LEGACY PRESCHOOL
LOVING · LEARNING · GROWING

Fax # 303-648-4277

General Health Appraisal

Child's Name _____ Date of Birth_____

Address _____ Phone_____

Past Illnesses: Check those child has had and give approximate dates:

o Chicken Pox o Whooping Cough o Hay Fever o Rubella o Rheumatic Fever o Asthma

o Poliomyelitis o Mumps o Rubella o Diabetes o Epilepsy o Other _____

This child o is o is not physically or emotionally able to participate in the Legacy Preschool's Program.

Comments: _____

Surgery\Accidents\Illnesses\Chronic Concerns:

_____

Describe any physical condition requiring special attention:

_____

_____

Medication(s) Prescribed: _____ Allergies: _____

If Tuberculin Test given: Date _____ Result _____

If Chest X-ray taken: Date _____ Result _____ Vision _____ Hearing _____

PLEASE RECORD IMMUNIZATIONS AND DATES ADMINISTERED ON THE COLORADO DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION AND ATTACH TO THIS FORM.

Date of most recent examination of child: _____ Date of next examination: _____

Please print: Name of Physician/Health Care Provider: _____

Address _____

City, State _____ Zip _____

Phone _____

_____ _____

Signature of licensed physician or licensed nurse practitioner **Date**

Legacy Preschool must obtain a signed and dated statement of each child's current health status that indicates the child's abilities and/or limitations to participate in their regularly scheduled childcare program. This report is to be filled out by a licensed physician or other health care professional who has seen the child in the last twelve months.

This form must be signed by a physician and must have a copy of the immunization records attached.

Updated 9.18.21