ASPEN CREEK ACADEMY

GROWING THE FUTURE

Physician's Health Form

Parent: *Please complete*

Child's Name:_____ Birth date:_____

Allergies: ☐None ☐Yes, describe_____

Type of Reaction:_____

Diet: ☐Breast Fed ☐Formula

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 back for sleep.

I,_____, give consent for my child's health provider, school, or camp personnel to discuss my child's health concerns with my doctor/primary physician and their affiliates. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school or camp. **Fax Number: 303-973-1504**

_____ Date:_____/_____/_____

Parent or Legal Guardian Signature — 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 ☐Vision ☐Hearing ☐Hospitalizations ☐Severe Allergies ☐Other (dental, nutritional, behavior, etc.)

Explain above concerns (if necessary to childcare provider):_____

Current Medications/Special Diet: ☐None ☐Describe:_____

_____

Separate medication authorization form required for medication given in childcare

Immunizations:

☐ Up-to-date

☐See attached immunization form

☐Administered Day:_____

Health Care Provider 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 in this form

_____ ____/____/____

Signature certifying form was reviewed — Today's Date

Office Stamp: