GENERAL HEALTH APPRAISAL FORM

GRALAND

A complete physical examination is required for ALL NEW STUDENTS. All 5th, 6th, 7th, and 8th grade students must have this form completed annually in order to participate in sports and overnight trips.

PARENT: *Please complete*

Student's Name: _____ DOB: _____ Grade in 2012/13 _____

Allergies? _____ Please describe: _____

Type of reaction: _____

Special diet/restrictions? _____ Please describe: _____

Other health concerns? _____ Please describe: _____

I, _____, give consent for my child's health care provider and school personnel to discuss my child's health concerns if needed. My child's health provider may fax this form (and applicable attachments) to my child's school. School fax number: 303-336-3720, ATTN: Megan Schmid, School Nurse

_____ 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 most recent Well Child Exam: _____ Weight: _____ Height: _____ B/P: _____

Significant health concerns: Check all that apply

☐ NONE ☐ Asthma/Reactive Airway Disease ☐ Seizures ☐ Diabetes ☐ Developmental Delays ☐ Vision

☐ Hearing ☐ Hospitalization ☐ Severe Allergies ☐ Other:_____

Explain above concerns (if necessary, include instructions to school/child care):

_____

Current medications/special diet?_____ Please describe: _____

_____

Immunizations: ☐ Up-to-Date ☐ See attached immunization record

HEALTH CARE PROVIDER: *Signature*

Next Well Child Visit: ☐ Per AAP Guidelines* or ☐ At Age _____

This child is healthy and may participate in all routine school activities, sports, trips (including overnight/off-campus), childcare, physical education classes, and/or interscholastic sports. Any concerns or exceptions are identified on this form.

_____ _____

Signature of Health Care Provider (certifying above information was reviewed) — Date Signed

OFFICE STAMP/ADDRESS

Colorado Chapter of the American Academy of Pediatrics (AAP) and Qualistar/Healthy Child Care Colorado support the need for the above information for schools and childcare.
*The AAP recommends health appraisal visits at ages 3, 4, 5 The, 6, and at least every 1 to 2 years throughout childhood.

Mail to: Graland Country Day School
ATTN: Megan Schmid, School Nurse
30 Birch St Denver, CO 80220
Fax to: 303-336-3720
Email to: gralandhealthoffice@graland.org

Medication Administration Permission
Graland Country Day

The parent/guardian of _____ ask that school staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The school agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School or Child Care

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

Medication: _____

Dosage: _____ **Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

	PERMISSION TO SELF-CARRY MEDICATION (NOT AN OPTION FOR STUDENTS BELOW GRADE 5 OR FOR CONTROLLED MEDICATIONS.)
☐	**I give my permission for this student to self-carry his/her medication and have instructed him/her in its proper use. _____ (Signature of Health Care Provider)**
☐	**I give my permission for my child to self-carry medication at school. I understand that this privilege can be revoked for misuse. _____ (Signature of Parent/Guardian)**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.
Thank you!