PIKES PEAK Christian school

PRESCHOOL
Student Health Examination Record
PPCS Fax: 719-598-1491

Office Use Only:
Grade Level/Class: _____
Homeroom: _____

Parent: *Please Complete*

Child's Name:_____**Birthdate**(MM/DD/YY):_____

Allergies: □None □Describe:_____

Type of reaction:_____

□ Special Diet: _____

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: 719-598-1491

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

Health Care Provider: *To be filled out by licensed practitioner*

Date of Last Exam: _____ **Recent Weight:** ____ **HCT:** ____ **BP:** ____ **Lead Level:** ____
Physical Exam: □Normal □Abnormal (see explanation of significant health concerns)
Significant health concerns: □None □Reactive Airways Disease □Seizures □Diabetes □Developmental Delays □Vision □Hearing □Hospitalizations □Severe Allergies □Other (dental, nutritional, behavior, etc.)_____

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

_____

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

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

Next Well Visit: Date_____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:

_____
Signature of Health Care Provider Date