



For Office Use

Next exam due _____

Immunization Certificate _____

GENERAL HEALTH APPRAISAL/ EXAM FORM

Please complete and return to: 444 Detroit Street, Denver, 80206 or FAX 303.322.77949

TO BE COMPLETED BY CHILD'S HEALTH CARE PROVIDER (Please print)

Child's Name _____ Date of Birth _____

DATE OF MOST RECENT EXAM _____

Allergies _____ * Type of Reaction _____

** If reaction is severe, please include a Health Care Plan.*

Diet Restrictions _____

Other conditions or concerns _____

Treatment required for the above _____
Please include a Health Care Plan.

Is the child on any medication? _____ If yes, what and why _____

In your opinion is this child physically, emotionally, and developmentally able to function in a school program? _____
Please explain any concerns _____

Is there anything about this child's condition that would require special attention in a classroom situation? _____
If yes, what? _____

Do you have any concerns about this child's vision or hearing? _____

Additional Comments: _____

Physician's Name _____ Phone _____

Address _____

Signature _____ Date _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

I, _____, give consent for my child's health care provider to complete this form
(Print name of parent/legal guardian)
for Children's Garden Montessori School and understand that a physical exam and updated form are required by Human Services
for all preschool children annually from the date of most recent exam (bi-annually for children under 2 years).

Signature _____ Date _____