

Health Appraisal Form

PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____ dd / mm / yyyy

Grade: _____ School: _____

Parent/Guardian's Name: _____ Phone Number: _____

Address:

MEDICAL HISTORY

Medical History:

IMMUNIZATION LIST

Immunization List:

ALLERGIES

Allergies:

MEDICATION LIST

Medication 1

Name: _____ Dosage: _____

Time: _____

Notes:

Medication 2

Name: _____ Dosage: _____

Time: _____

Notes:

Medication 3

Name: _____ Dosage: _____

Time: _____

Notes:

Medication 4

Name: _____ Dosage: _____

Time: _____

Notes:

Medication 5

Name: _____ Dosage: _____

Time: _____

Notes:

PHYSICAL EXAMINATION

Height: _____ Weight: _____

BMI and Weight Status: _____ Blood Pressure: _____

Vision: _____ Hearing: _____

SUMMARY AND NOTES

Summary and Notes:

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION

Physical Education/Sports/Playground/Work Qualification:

- ☐ Free from all contagions and physically qualified for all physical education/sports/playground/work activities
- ☐ Limited contact: cheerlead, gymnastics, skiing, volleyball, cross-country, basketball, etc.
- ☐ Non-contact: Badminton, golf, swimming, tennis, archery, etc.

Specify Medical Accommodation Needed for School:

Known or Suspected Disabilities:

Restrictions and Protective Equipment Requirements:

SIGNATURES

Provider's Name: _____

Provider's Signature: _____
Date: _____ dd / mm / yyyy

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____
Date: _____ dd / mm / yyyy