Statement of Health Status

Family of Christ Child Development Center
675 Baptist Rd. ♦ Colorado Springs, CO 80921
Phone 719-481-0796 ♦ Fax 719-481-1366
www.foccs.net

Child's Name_____ **Date of Birth:**_____

Current Health Issues

Y N

☐ ☐ Allergies: Please List: Food _____ Medication _____ Other _____
☐ ☐ History of Anaphylaxis to: _____
☐ ☐ Epi-Pen® *(If yes attach an Allergy Alert Plan available on-line and have a medical professional sign.)*
☐ ☐ Asthma (*If yes attach an Asthma Action Plan available on-line and have a medical professional sign.)*
☐ ☐ Diabetes: ☐ Type I ☐ Type II (*If yes attach a Diabetes Management Plan and have a medical professional sign.*)
☐ ☐ Seizure disorder:_____ (*If yes attach a Seizure Response Plan and have a medical professional sign.*)
☐ ☐ Other (Please Specify) _____

Current Medications: *List all prescription, non-prescription and herbal remedies used on a regular basis. Circle those that will need to be administered at school and complete a separate Medication Permission Form available on-line for each medication and have a medical professional sign.*

_____

Physical Examination **Date of My Last Examination** (must be within the last 12 months) _____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP:_____

(Check = Normal/If abnormal, please describe.)

☐ General_____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin_____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT_____ ☐ Abdomen_____ ☐ Other _____
☐ Dental/Oral_____

Screening:	**Pass**	**Fail**		**Pass**	**Fail**		**Pass**	**Fail**
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐			
Stereopsis	☐	☐						

Targeted TB Skin Testing: ☐ Low risk (no PPD done) ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors): Date of PPD:_____; Results:_____mm.
Referred for evaluation to:_____

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N I have examined the above student and reviewed his/her health history. It is in my opinion that he/she is medically cleared to participate fully in all child care/school activities.

☐ Y ☐ N Immunizations are complete and a record is attached: If no, please attach the Colorado Immunization Notification and Plan or sign the exemption if your child has had an immunization exemption.

_____ _____
Signature of Examiner Circle: MD, DO, NP, PA Date Please print name of Examiner

_____
Group Practice Telephone

_____
Address City State Zip Code

I _____ give consent for my child's health care provider and child care provider to discuss my child's health concerns.

_____ _____
Parent or Legal Guardian Signature Date

Please attach any additional information as needed for the health and safety of the student.