

Statement of health status for enrollment

This report is to be filled out by a licensed physician or other health care professional who has seen the child in the last twelve months.

Child's Name _____ Sex _____ DOB _____
Address _____

Past Illnesses (check those the child has had and give approximate dates):

- | | | |
|--|--|--|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Rubeola _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Poliomyelitis _____ | <input type="checkbox"/> Other _____ |

Comments: _____

Surgery/Accidents/Illnesses/Chronic Health Problems:

Describe any physical condition requiring the facility's special attention:

Medication(s) prescribed: _____

Allergies: _____

Prescribed routine: _____

Tuberculin test given: Y N Date: _____ Result: _____

Chest ray taken: Y N Date: _____ Result: _____

Vision: _____ Hearing: _____

Please record immunizations and dates administered on the Colorado Department of Health Certificate of immunization and attach to this form.

Date of my most recent examination of the child: _____

Signature of Physician/Health Care Professional

Date

Please print:

Name of Health Care Professional

Address

City, State and Zip

Telephone