Portland Public Schools Head Start
4800 NE 74th Ave
Portland, OR 97218
Phone: 503-916-5724 Fax: 503-916-2714

Health Appraisal Form

Child's Name: _____ **Birth date:** _____

1) **Is child up to date on schedule of age appropriate preventative & primary health care?**

❑ YES ❑ NO

Last Well Child Exam Date: _____

Hearing Screened (Audiometer, OAE, AABR)	❑ PASS	❑ FAIL	❑ Not screened
Vision Screened (Acuity, Oculus Alignment)	❑ PASS	❑ FAIL	❑ Not screened
Immunizations Up to Date	❑ YES	❑ NO	
Blood Lead Test	❑ YES Level:___		❑ Not screened
Hemoglobin Test	❑ YES Level: ____		❑ Not screened

Height: _____ Weight: _____

2) **Does child have any conditions/diseases or follow-up care that staff should be aware of?**
(Anemia, speech/developmental delays, birth defects, chronic illnesses, disabilities, dental caries, high/low BMI, etc.)

❑ NONE

❑ Seizures ❑ Cardiac Problems ❑ Asthma ❑ Bleeding Disorder ❑ Diabetes

❑ Development/Speech concerns ❑ Other:_____

Comments:_____

_____

3) **Current medications:** _____ ❑ NONE

4) **Allergies:** _____ **EpiPen needed?** ❑ YES ❑ NO

Medical Providers Signature:_____ Date:_____

Medical Providers Name (please print):_____

Address (please print): _____Phone Number_____