HEAD START of LANE COUNTY

221 "B" Street · Springfield OR 97477-4522
(541) 747-2425 · FAX (541) 747-6648 · http://www.head-start.lane.or.us

HEALTH APPRAISAL

VALORACIÓN DE SALUD

Child's Name / *Nombre del niño/a*:_____ **Birthdate** / *Fecha de nac*:_____

Physician's Name / *Nombre del doctor*:_____

I give my permission for mutual exchange of information concerning my child / *Doy permiso para que se intercambie información con respecto a mi hijo/a.*

❒ **Parent permission received**/ *Permiso recibido del padre de familia / tutor legal*

Parent's Name/*Nombre del padre de familia / tutor legal*: _____

Parent's Signature/*Firma del padre de familia / tutor legal*: _____

MEDICAL PERSONNEL ONLY

PARA USO DEL PERSONAL MÉDICO SOLAMENTE

Date of last exam: _____ Height: _____ Weight: _____	Iron Deficiency Anemia? ❒ No ❒ Yes

1) Are there any conditions that need accommodations in the classroom, or require follow-up treatment? (Asthma, allergies, speech delays, birth defects, illnesses, etc)

   ❒ No ❒ Yes, please explain under "Comments"

2) Are there any medications that should be dispensed in the classroom?

   ❒ No ❒ Yes, please list under "Comments"

3) Is he/she up to date on a schedule of age appropriate preventative and primary health care?

   ❒ No ❒ Yes

4) Are you serving as this child's "Medical Home" or Primary Care Provider?

   ❒ No ❒ Yes

Comments:

_____ _____

Signature of Examining Physician Date

PLEASE RETURN THIS FORM TO HEAD START OF LANE COUNTY OR FAX TO 747-6648

(R:4/23-C:4/02) white

RA: Scan to CP Health Attachments

Original: Keep in locked file/shred at end of year