

**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 \_\_\_\_\_

<b>Screening:</b>	<b>Pass</b>	<b>Fail</b>		<b>Pass</b>	<b>Fail</b>		<b>Pass</b>	<b>Fail</b>
Vision: Right Eye	<input type="checkbox"/>	<input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/>	<input type="checkbox"/>	Postural Screening	<input type="checkbox"/>	<input type="checkbox"/>
Left Eye	<input type="checkbox"/>	<input type="checkbox"/>	Left Ear	<input type="checkbox"/>	<input type="checkbox"/>			
Stereopsis	<input type="checkbox"/>	<input type="checkbox"/>						

**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.*