HEAD START of LANE COUNTY

221 B Street · Springfield OR 97477-4522
541-747-2425 · FAX: 541-747-6648 · http://www.hsolc.org

HEALTH APPRAISAL

VALORACIÓN DE SALUD

WebCAF #: _____

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

Physician's Name / *Nombre del pediatra*: _____ **Fax #**: 541- _____

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

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

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

Parent's Signature / *Firma del padre/madre/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

Any questions? Call 541-747-2425 ext 1238.

PLEASE RETURN THIS FORM TO HEAD START OF LANE COUNTY OR FAX TO 541-747-6648

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WHITE : Health Records
COPY : Site File, Section 3