

Seeds of Learning
P.O. Box 5831
Pagosa Springs, CO 81147
Fax # 970-264-2022
Health Form

Children who enroll **must** submit a signed and dated statement of the child's current health status. ***This report is to be filled out by a licensed physician or a licensed nurse practitioner that has seen the child in the last 12 months.*** These are state regulations.

Child's Name _____ Sex _____ Date of Birth _____
Address _____

School Health Evaluation

Physician: Completion of this evaluation is necessary for enrollment at Seeds of Learning. Examination indicates his/her ability to participate in all activities.

Past Illnesses--Check those the child has had and give approximate dates:

Chicken Pox _____	Rubeola _____	Rubella _____
Rheumatic Fever _____	Asthma _____	Hay Fever _____
Diabetes _____	Mumps _____	Epilepsy _____
Whooping Cough _____	Hepatitis _____	Strep Throat _____
Other _____		

This child is ____ is not ____ physically or emotionally able to participate at Seeds of Learning

Comments _____

Surgery, accidents, illness, and chronic or handicapped conditions:

Chronic Medical Conditions:

Medication(s) prescribed:

Allergies and/or Special Diet that staff should be aware of _____ and prescribed routine:

If tuberculins test given: Date _____ Result: _____

If chest X-ray taken: Date _____ Result: _____

Physical findings (include vision/hearing, if tested): _____

Comment/Follow up requirements for abnormal results and/or immunization updates:

Date of my most recent examination of child: _____

Signature of licensed physician or licensed nurse practitioner

Date

Please print name and address: _____