



18403 Longs Way #107 Parker, CO 80134  
Ph: 303-841-1064 Fax: 303-840-1085  
[www.kineticsyouth.com](http://www.kineticsyouth.com)

## General Health Appraisal

Parent please complete and sign

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Allergies: \_\_\_\_\_ none or describe below: \_\_\_\_\_

If allergies are present, what type of reaction occurs?  
\_\_\_\_\_

Other health issues such as diabetes, asthma, respiratory, heart:  
\_\_\_\_\_

Behavioral health issues requiring special attention by staff:  
\_\_\_\_\_

I, \_\_\_\_\_ give consent for my child's health care provider to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my Kinetics Youth Center.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Health Care Provider:

Date of last checkup: \_\_\_\_\_

Physical Exam: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal (please specify below)  
\_\_\_\_\_

#### Health concerns:

- Severe Allergies     Reactive Airway Disease     Asthma     Seizures     Diabetes  
 Developmental Delays     Behavior concerns     Vision     Hearing     Dental  
 Nutrition     Other \_\_\_\_\_

If Significant Health concerns exist please fill out a Health Care Plan for Kinetics or attach your own Care Plan for this child.

Current Medications/Special Diet: \_\_\_\_\_ None or \_\_\_\_\_ Describe below  
\_\_\_\_\_  
\_\_\_\_\_

If medication is to be given during childcare hours, a separate medication authorization is required.

### Provider Signature:

Next well visit \_\_\_\_\_ Age: \_\_\_\_\_

This child is healthy and may participate in all routine activities in child care or camp program. Any concerns or exceptions are identified on this form.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

### Office Stamp

or write Name, Address, Phone #



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**Medication Administration in School or Child Care**  
**Please keep in case medications are needed during camp dates**

The parent/guardian of \_\_\_\_\_ ask that school/child care staff give the  
(Child's name)  
following medication \_\_\_\_\_ at \_\_\_\_\_  
(Name of medicine and dosage) (Time(s))  
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.  
It is the parent/guardian's responsibility to furnish the medication.  
The parent agrees to pick up expired or unused medication within one week of notification by staff.

**Prescription medications** must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

**Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

\_\_\_\_\_  
Parent/Legal Guardian's Name                      Parent/Legal Guardian Signature                      Date  
\_\_\_\_\_  
Work Phone    Home Phone

\*\*\*\*\*

**Health Care Provider Authorization to Administer Medication in School or Child Care**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Route: \_\_\_\_\_  
To be given at the following time(s): \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Purpose of medication: \_\_\_\_\_  
Side effects that need to be reported: \_\_\_\_\_  
Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
Signature of Health Care Provider with Prescriptive Authority License Number

\_\_\_\_\_  
Phone Number    Date

Please ask the pharmacist for a separate medicine bottle to keep at school/child care. Thank you!