



Shepherd of the Hills Christian School

7691 S. University Blvd. Centennial, CO 80122 303-798-0711 ShepherdHills-school.org

Child's Statement of Health Status for Enrollment in Preschool, BASE Camp, or Child Care

For every child who enrolls in preschool/childcare programs, the preschool/childcare facility must obtain a signed and dated statement of the child's current health status, which indicates the child's abilities and/or limitations to participate in a regularly scheduled preschool/childcare program. This report is to be filled out by a licensed physician or other healthcare professional who has seen the child in the last twelve months (or within the last six months if your child is less than two and one half years of age).

Child's Name _____ Gender _____ Date of Birth _____

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 | _____ Poliomyelitis | _____ Other |

Comments: _____

Please list any Hospitalizations/Surgeries/Accidents/Illnesses/Chronic Health Problems:

Describe significant health concerns, physical conditions or developmental delays requiring the facility's special attention: _____

Current Medications/Special Diet: _____

Allergies: _____ reaction and prescribed routine _____

Vision _____ Hearing _____

PLEASE RECORD IMMUNIZATIONS AND DATES ADMINISTERED ON THE COLORADO DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION AND ATTACH TO THIS FORM.

Date of my most recent examination of the child: _____

Next Well Visit: _____ Per AAP Guidelines <or> at Age _____

The child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified above.

Signature of licensed physician or health care provider _____ Date _____

Please print:
(or stamp) _____
Name of physician/health care professional

Address

Phone
