STATE OF UTAH
UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH SERVICES

UNIFIED HEALTH APPRAISAL FORM

TO PHYSICIANS: This Unified Health Appraisal Form may be used for reporting any or all of the following:
1. Physical examination
2. Activity restrictions
3. Medications to be taken at school
4. Recommended remedial or follow-up services
5. Athletic camp or other examinations

TO SCHOOL PERSONNEL: This Unified Health Appraisal Form and Immunization Record should become a permanent part of each student's cumulative record folder. A copy should be made and sent to the new school whenever a student transfers.

NAME ____________________________ DATE OF BIRTH ____________ SEX F M
PARENT(S)/GUARDIAN __________________ SCHOOL/ORGANIZATION __________________
________________________ SCHOOL DISTRICT __________________
ADDRESS __________________________ VISUAL ACUITY
________________________ ___________________ Right: 20/_____ Left: 20/_____
PHONE ________ EMERGENCY PHONE ________ With correction _____ Without correction _______

I. The above named patient was examined on ____________ and found to

☐ be free of illness or conditions which would interfere with SCHOLASTIC performance.
☐ be free of illness or conditions which would interfere with SPORTS participation.
☐ have the following MEDICAL CONDITIONS:

1. __________________________

2. __________________________

II. The following RESTRICTIONS should be placed on ACTIVITY: ☐ None ☐ See Below

1. __________________________

2. __________________________

3. __________________________

Restrictions are to be in force until ____________

III. The following MEDICATIONS are prescribed and may be taken at school: ☐ None ☐ See Below

<table>
<thead>
<tr>
<th>Medication</th>
<th>Medical Condition # from above</th>
<th>Dose (mg)</th>
<th>Form (tab, tsp)</th>
<th>Time</th>
<th>Stop Date</th>
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IV. Other Récommendations: ☐ None ☐ See Below

1. __________________________

2. __________________________

3. __________________________

4. __________________________

For further information, please contact me at the following address or telephone number.

PRINTED OR STAMPED NAME, ADDRESS AND PHONE NUMBER OF EXAMINING PHYSICIAN

Name ____________________________ Address ____________________________ Phone ____________________________

Physician's Signature ____________________________ , M.D.

Date ____________________________