

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)		DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code) MI
		WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing	
☐	☐	☐	3 Eczema or Frequent Skin Rashes	
☐	☐	☐	4 Convulsions/Seizures	
☐	☐	☐	5 Heart Trouble	
☐	☐	☐	6 Diabetes	
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
☐	☐	☐	9 Shortness of Breath	
☐	☐	☐	10 Speech Problems	
☐	☐	☐	11 Menstrual Problems	
☐	☐	☐	12 Dental Problems: Date of Last Exam / /	
☐	☐	☐	Other (please describe): _____	
☐	☐	☐	Does your child take any medication(s) regularly?	If yes, list medications:
Reason for Medication _____				
_____ / /				Was the health history reviewed by a health professional?
Parent/Guardian Signature _____ Date _____				☐ Yes ☐ No Examiner's Initials: _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity				☐	☐	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance						Weight				
			Other:				☐	☐	Other:				
☐	☐	HEARING	Audiometer				☐	☐	HEMOGLOBIN / HEMATOCRIT				
		Date: / /	Other:				☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	URINALYSIS	Sugar				☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Albumin						Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			
			Microscopic										
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl				NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS			
Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*			
VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)
	2		Influenza (IIV/LAIV)
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)
	2	5	
	3	6	Human Papillomavirus (HPV4/HPV2)
Tdap	1		
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type
	2	4	
Polio (IPV/OPV)	1	3	Type of Vaccine(s)
	2	4	Date of Vaccine(s)
Pneumococcal Conjugate (PCV7/PCV13)	1	3	
	2	4	
Rotavirus (RV1/RV5)	1	3	
	2		
Measles, Mumps, Rubella (MMR)	1	2	
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:		Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable	
I certify that the immunization dates are true to the best of my knowledge		*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.	
Health Professional's Signature _____		Parent/Guardian refused immunizations: ☐	
Title _____		Date ____/____/____	

		SECTION IV - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)	
No	Yes	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:	
☐	☐		
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other	
Other Recommendations			

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)	
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____	
child's name	
Dentist's Signature _____ Date ____/____/____	

PHYSICIAN'S SIGNATURE			
Examiner's Signature _____	Date ____/____/____	Examiner's Name (Print or Type) _____	Degree or License _____
Number & Street _____	City _____	MI _____	ZIP Code _____ Telephone (____) _____

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.