

Developed in Cooperation With:

### HEALTH APPRAISAL

Department of Human Services  
Departments of Community Health, and Education;  
Michigan State Medical Society;  
Michigan Association of Osteopathic Physicians and Surgeons

- School
- Children's Group
- Child Care Center
- Child Caring Institution
- Other:

Dear Parent or Guardian: The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section I. Section II may be certified by transcription of information from the certificate of immunization. The remaining sections (111, IV, V) 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 \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Number & Street City Zip  
 Parent's or Guardian's Name \_\_\_\_\_ Telephone (Home) \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_ Telephone (Work) \_\_\_\_\_  
 Number & Street City Zip

#### SECTION I -- HEALTH HISTORY

Is your child having any of the problems listed below?

Yes	No
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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)		
8. Trouble with passing urine or bowel movements		
9. Shortness of breath		
10. Speech problems		
11. Menstrual problems		
12. Dental problems: date of last examination:		
13. Other		
Please explain any problem areas identified above:		

#### SECTION II --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	DATE ADMINISTERED			
	Type	Mo/Day/Yr.	Type	Mo/Day/Yr.
Hepatitis B (Hep B)	1		3	
	2			
DTaP/DTP/DT/Td/Tdap (Specify Type)	1		5	
	2		6	
	3		7	
	4		8	
Haemophilus Influenza type b (HIB)	1		3	
	2		4	
Polio (IPV/OPV) (Specify Type)	1		3	
	2		4	
Pneumococcal Conjugate (PCV7)	1		3	
	2		4	
Rotavirus (Rota)	1		3	
	2			
Measles, Mumps, Rubella (MMR)	1		2	
Varicella (Chickenpox)	1		2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: _____				
Hepatitis A (Hep A)	1		2	
Influenza TIV/LAIV	1		3	
	2		4	
Meningococcal MCV4/MPSV4 (Specify Type)	1		2	
Human Papillomavirus HPV	1		3	
	2		4	
Other Vaccines: (Specify Date & Type)				

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable \_\_\_\_\_

Does your child take any medications regularly?  Yes  No  
 If yes, what medication? \_\_\_\_\_  
 Reason for Medication: \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_

I certify that the immunization dates are true to the best of my knowledge

Validating Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

\*According to Act 368, Public Acts 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 waiver forms are properly prepared, signed, and delivered to school administrators. Forms for these exemptions are available at your school or local health department.

**SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS**

**EXAMINATIONS AND/OR INSPECTIONS**

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS


**TESTS AND MEASUREMENTS**

	Within Normal Limits	Under Care	Referred		Within Normal Limits	Under Care	Referred
Vision Tested? <input type="checkbox"/> Visual Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Muscle Imbalance Date _____ <input type="checkbox"/> Other _____ <small>(Specify)</small>				Urinalysis Done? <input type="checkbox"/> Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Albumin Date _____ <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Audiometer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ <small>(Specify)</small> Date _____				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____			
Hemoglobin/Hemotocrit Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No				Height _____ Weight _____ Other:			
Blood Lead Level Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Result _____				Blood Lead level recommended 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 noted above.			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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Tuberculin Test (if given)      Date \_\_\_\_\_      Type \_\_\_\_\_       Negative       Positive \_\_\_\_\_ mm.

**SECTION IV -- RECOMMENDATIONS**

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action?  Yes  No  
 If yes, please explain:

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Should the student's activity be restricted because of any physical defect or illness?  Yes  No    If yes, check below and explain degree of restriction:

Classroom       Playground       Gymnasium       Swimming Pool       Competitive Sports       Camp       Other

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Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_ Examiner's Name (print or type) \_\_\_\_\_ Degree or License \_\_\_\_\_

Number & Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

**SECTION V -- DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)**

I have examined \_\_\_\_\_ teeth and make the following recommendations as for treatment:

Child's Name \_\_\_\_\_

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\_\_\_\_\_  
 Dentist's Signature      Date

**COMMENTS**
