Developed in Cooperation With:

Department of Human Services,
Departments of Community Health, and Education;

Michigan State Medical Society;

Michigan Association of Osteopathic Physicians and Surgeons

HEALTH APPRAISAL

☐ 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
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:

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, what medication? ______________

Reason for Medication: ______________

Parent's Signature: ______________

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. *

VACCINE	DATE ADMINISTERED Type	Mo/Day/Yr.	Type	Mo/Day/Yr.
DTaP/DTP/Td (Specify Type)		1.		6.
		2.		7.
		3.		8.
		4.		9.
		5.		10.
Haemophilus influenzae type b (HIB)		1.		3.
		2.		4.
POLIO IPV/OPV (Specify Type)		1.		4.
		2.		5.
		3.		
Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated.				
MMR		1.		2.
Varicella (Chickenpox)		1.		2.
Chickenpox History of Disease		☐ Yes ☐ No		Date:
Hepatitis B HBV		1.		3.
		2.		
Pneumococcal Conjugate (PCV)		1.		3.
		2.		4.
Other Vaccines				
Indicate physician diagnosis or laboratory evidence of immunity as applicable				
VACCINES WAIVED DUE TO REACTIONS/CONTRAINDICATIONS/ RELIGIOUS OBJECTIONS				

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

	Normal	Under Care	Referred		Normal	Under Care	Referred
Vision Tested? ☐ Yes ☐ No Date______________ ☐ Visual Activity ☐ Ocular Muscle ☐ Other_______				Urinalysis Done? ☐ Yes ☐ No Date______________ ☐ Sugar ☐ Albumin ☐ Microscopic			
Hearing Tested? ☐ Yes ☐ No Date___________________ ☐ Audiometer ☐ Other_________				Blood Pressure Measured? ☐ Yes ☐ No Reading_________________			
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No				Height_____________ Weight_________ Other:			
Blood Lead Level Tested? ☐ Yes ☐ No Date______________ Reading__________				Blood Lead level recommended for all children age six and under			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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:

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

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

Dentist's Signature Date

COMMENTS