

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

SECTION I - HEALTH HISTORY

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Resolved</td> <td style="width: 10%;"></td> <td style="width: 50%;"># Is your child having any of the problems listed below?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td colspan="5" style="padding-top: 10px;"><input type="checkbox"/> Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="5">Reason for Medication _____</td> </tr> <tr> <td colspan="5" style="text-align: center;">/ /</td> </tr> <tr> <td colspan="4" style="text-align: center;">Parent/Guardian Signature</td> <td style="text-align: center;">Date</td> </tr> </table>	Yes	No	Resolved		# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	<input type="checkbox"/> Does your child take any medication(s) regularly?					Reason for Medication _____					/ /					Parent/Guardian Signature				Date	<p>Birth History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Resolved		# Is your child having any of the problems listed below?																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____																																																																																							
<input type="checkbox"/> Does your child take any medication(s) regularly?																																																																																											
Reason for Medication _____																																																																																											
/ /																																																																																											
Parent/Guardian Signature				Date																																																																																							

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
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT Date: / /	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg: <input type="checkbox"/> Pos: <input type="checkbox"/> mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	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		DATE ADMINISTERED MM/DD/YYYY
Hepatitis B (HepB)	1	3	2
	2		3
DTaP/DTP/DT/Td	1	4	4
	2	5	2
	3	6	
Tdap	1		
Haemophilus Influenzae type b (HIB)	1	3	Type of Vaccine(s) Date of Vaccine(s)
	2	4	
Polio (IPV/OPV)	1	3	1
	2	4	2
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3
	2	4	
Rotavirus (RV1/RV5)	1	3	OTHER Vaccines Specify Date & Type
	2		
Measles, Mumps, Rubella (MMR)	1	2	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			*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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.
I certify that the immunization dates are true to the best of my knowledge			
_____ Health Professional's Signature		_____ 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 sealing or other actions? If yes, please explain:	
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other	
<input type="checkbox"/>	<input type="checkbox"/>		
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 Department of Health and Human Services, Education, 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.