HEALTH APPRAISAL

Developed in Cooperation With:
Department of Consumer & Industry Services
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 from the certificate of immunization. The remaining sections (III, IV, and 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 _____ Phone (home) _____
Last First Middle

Address _____ Phone (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 medication regularly? ☐ YES ☐ NO

If yes, what medication? _____

Reason for medication: _____

Parent Signature _____

SECTION II - IMMUNIZATION

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	
DPT/DT/Td	Type Mo/Day/Year	Type Mo/Day/Year
DTaP	1	6
(Specify Type)	2	7
	3	8
	4	9
	5	10
Haemophilus	1	3
Influenza type b (HIB)	2	4
POLIO	1	4
(Specify Type)	2	5
OPV/IPV	3	
Note: If Measles, Rubella, or Mumps vaccinations were given before 12 months of age, the dosage must be repeated.		
MMR	1	2
Varicella	1	3
(Chickenpox)	2	4
Hepatitis B	1	3
	2	
Pneumococcal	1	3
Conjugate (PCV)	2	4
Other Vaccines		
Indicate physician diagnosis of disease or laboratory evidence of immunity as applicable		
VACCINES WAIVED DUE TO REACTIONS/ CONTRA-INDICATIONS/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 the 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 MEASUREMENTS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

	Normal	Under Care	Referred		Normal	Under Care	Referred
Vision Tested? ☐ Visual Acuity YES NO ☐ Ocular Muscle Date: ☐ Other				Urinalysis Done? ☐ Sugar YES NO ☐ Albumin Date: ☐ Microscopic			
Hearing Tested? Audiometer YES NO Other Date:				Blood Pressure Measured? YES NO Reading:			
Hemoglobin/Hemotocrit Tested? YES NO				Height: Weight: Other:			
Blood Lead Level Measured? YES NO Date: Reading:				Blood Lead Level recommened 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 students 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

Examiners Signature | Date | Examiners 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:

_____

Dentist Signature Date

COMMENTS