

Developed in Cooperation With:
 Departments of Consumer and Industry Services
 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 (III, 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. Convulsion/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's 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:	TYPE	DATE ADMINISTERED	
		Mo./Day/Yr.	Mo./Day/Yr.
DTP/DT/Td DTaP (Specify Type)		1. _____	6. _____
		2. _____	7. _____
		3. _____	8. _____
		4. _____	9. _____
		5. _____	10. _____
Haemophilus influenzae type b		1. _____	3. _____
		2. _____	4. _____
POLIO (Specify Type) OPV/IPV		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. _____
			Mo./Day/Yr.
Varicella		1. _____	
		2. _____	
Hepatitis B		1. _____	3. _____
		2. _____	
OTHER VACCINES			

Indicate physician diagnosis of disease 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Visual Acuity <input type="checkbox"/> Ocular Muscle <input type="checkbox"/> Other _____				Urinalysis Done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Sugar <input type="checkbox"/> Albumin <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	<input type="checkbox"/> Audiometer <input type="checkbox"/> Other _____				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____				
Hemoglobin/Hematocrit Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No					Height _____ Weight _____ Other: _____				

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 _____ Child's Name _____ teeth and make the following recommendations as to treatment: _____

_____ Dentist's Signature _____ Date _____

COMMENTS:
