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 (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 _____ (Last / First / Middle) Sex _____ Date of Birth _____

Address _____ (Number & Street / City / Zip) Today's Date _____

Parent's or Guardian's Name _____ (Last / First / Middle) Telephone (Home) _____

Address _____ (Number & Street / City / Zip) Telephone (Work) _____

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	Type	DATE ADMINISTERED 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
Vision Tested? ☐ Yes ☐ No Date_____ ☐ Visual Activity ☐ Ocular Muscle ☐ Other_____			
Hearing Tested? ☐ Yes ☐ No Date_____ ☐ Audiometer ☐ Other_____			
Hemoglobin/Hematocrit Tested? ☐ Yes ☐ No			
Blood Lead Level Tested? ☐ Yes ☐ No Date_____ Reading_____			
Urinalysis Done? ☐ Yes ☐ No Date_____ ☐ Sugar ☐ Albumin ☐ Microscopic			
Blood Pressure Measured? ☐ Yes ☐ No Reading_____			
Height_____ Weight_____ Other:			
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