Developed in Co-operation With:
Departments of Social Services,
Public Health, and Education;
Michigan StateMedical 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, medicaton 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:_____

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.

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	
DTP/DT/Td (Specify Type)	Type	Mo./Day/Yr: 1.	Mo./Day/Yr: 6.
		2.	7.
		3.	8.
		4.	9.
		5,	10.
Haemophilus influenzae type b		1.	3.
		2.	4.
POLIO (Specify Type)		1.	4.
		2.	5.
OPV/IPV		3.	
Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated.			
MMR		Mo./Day/Yr: 1.	Mo./Day/Yr: 2.
Hepatitis B		1.	3.
		2.	
OTHER VACCINES			
Indicate physician diagnosis of disease or laboratory evi-dence 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

Forms for these exemptions are available at your school or local health department.

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SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

EXAMINATION 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 Acuity ☐ 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:			

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 (type or print) Degree or License
Number and Street City Zip Telephone

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ teeth and make the following recommendations as to treatment: Child's Name
Dentist's Signature Date

COMMENTS: