Developed in Cooperation With:
Departments of Consumer & 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 ______ (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 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:	TYPE	Mo/Day/Yr:
DTaP/DTP/DT/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. Mo/Day/Yr:		2. Mo/Day/Yr:
Varicella (Chickenpox)		1.		
		2.		
Hepatitis B HBV		1.		3.
		2.		
Pneumococcal Conjugate (PCV)		1.		3.
		2.		4.
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? ☐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:		______	______	______
Blood Lead Level Measured? ☐Yes ☐No Date ______ Reading ______		______	______	______	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