Developed in Cooperation With:		HEALTH	APPRAISAL			School		
Department of Human Services Departments of Community Health, and Education; Michigan State Medical Society; Michigan Association of Osteopathic Physicians and Surgeons						Children's Group Child Care Center Child Caring Institution Other:		
Dear Parent or Guardian: The following information is request out the information requested in Section I. Section II may be occompleted by a doctor, nurse, and dentist. (BE SURE TO BRING	ed so that the	school and parer			I, intellectual, an	d amaticaal ==	eds of the child. Fill IV, V) are to be	
PERSONAL Child's Name			MONNECONDO TO III			Data at Dist		
Last		First		Sex Middle		Date of Birth		
Address Number & Street			City		Zip	Today's Date_		
Parent's or Guardian's Name			****			phone (Home)		
Last Address		First	Middle		Tele	Telephone (Work)		
Number & Street			City		Zip			
SECTION I HEALTH HISTORY  Is your child having any of the problems listed below?	Yes	No	SECTION II -IMI Statements such as "UI	TO DATE" or "C	COMPLETE" will no	ot be accepted. A	dmission to school	
Allergies or reactions: (for example, food, medication, or other)	163	NO	may be denied on the b		DATE A	DMINISTERED		
Hay fever, asthma, or wheezing			Hepatitis B (Hep B)	Туре	Mo/Day/Yr.	Туре	Mo/Day/Yr.	
Eczema or frequent skin rashes				1		3		
Convulsions/Seizures			DTaP/DTP/DT/Td/Tdap	2				
5. Heart trouble			(Specify Type)	1		5 .		
6. Diabetes				2		6 .		
7. Frequent colds, sore throats, earaches				3 .		7 .		
(4 or more per year)				4		8		
8. Trouble with passing urine or bowel movements			Haemophilus Influenza type b	1		3		
9. Shortness of breath			(HIB)	2		4		
10. Speech problems			Polio (IPV/OPV) (Specify Type)	1 .		3 .		
11. Menstrual problems				2 .		4		
12. Dental problems: date of last examination:			Pneumococcal Conjugate (PCV7)	1		3		
13. Other				2		4		
			Rotavirus (RV)	1		3		
				2				
Please explain any problem areas identified above:			Measles, Mumps, Rubella (MMR)	1		2		
1000			Varicella (Chickenpox)	1		2		
			History of Chickenpox		es 🗆 No If	yes, Date:		
			Hepatitis A (Hep A)	1		2		
			Influenza	1				
			TIVILAIV			3		
			Meningococcal	2		4		
			MCV4/MPSV4 (Specify Type)	1		2		
			Human Papillomavirus	1		3		
			HPV4	2				
			Other Vaccines:					
			(Specify Date & Type)					
			Indicate and attach physic diagnosis or laboratory even of immunity as applicable	idence				
loes your child take any medications regularly?			l certify that the immunization dates are true to the best of my knowledge					
Reason for Medication:								
Parent's Signature:			Validating Signature		Title		Date	
					11110		Date	

<sup>\*</sup>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 Within Under Referred Within Under Referred Normal Normal Care Limits Limits Vision Tested? ☐ Visual Activity Urinalysis Done? ☐ Sugar ☐ Yes ☐ No ☐ Muscle Imbalance ☐ Yes ☐ No ☐ Albumin Date ☐ Other Date ☐ Microscopic Hearing Tested? ☐ Audiometer Blood Pressure Measured? ☐ Yes ☐ No ☐ Other\_ ☐ Yes ☐ No (Specify) Date Reading\_ Hemoglobin/Hemotocrit Tested? Height\_ Weight\_ ☐ Yes ☐ No Other: Blood Lead Level Tested? Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age ☐ Yes ☐ No six living in high risk areas should be tested at the same intervals \_\_Result \_ as noted above. ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS Tuberculin Test (if given) Date \_\_\_\_ Туре ☐ 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? If yes, please explain: Should the student's activity be restricted because of any physical defect or illness? The student's activity be restricted because of any physical defect or illness? The student's activity be restricted because of any physical defect or illness? ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Camp ☐ Other ☐ Classroom Examiner's Signature Date Examiner's Name (print or type) Degree or License Number & Street City 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