

☐ School☐ Children's Group☐ Child Care Center☐ Child Caring Institution☐ Other:

PERSONAL

Address _____ Telephone (Work) _____

Number & Street City Zip

SECTION II - IMMUNIZATIONS

Yes	No
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Please explain any problem areas identified above:

		History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date:	
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Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information. *

may be denied on the basis of this information.

VACCINES	DATE ADMINISTERED			
	Type	Mo/Day/Yr.	Type	Mo/Day/Yr.
Hepatitis B (Hep B)	1		3	
	2			
DTaP/DTaP/DTaP/DTaP (Specify Type)	1		5	
	2		6	
	3		7	
	4		8	
Haemophilus Influenza type b (HIB)	1		3	
	2		4	
Polio (IPV/OPV) (Specify Type)	1		3	
	2		4	
Pneumococcal Conjugate (PCV7)	1		3	
	2		4	
Rotavirus (RV)	1		3	
	2			
Measles, Mumps, Rubella (MMR)	1		2	
Varicella (Chickenpox)	1		2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date:				
Hepatitis A (Hep A)	1		2	
Influenza TIV/LAIV	1		3	
	2		4	
Meningococcal MCV4/MPSV4 (Specify Type)	1		2	
Human Papillomavirus HPV4	1		3	
	2			
Other Vaccines: (Specify Date & Type)				

Indicate and attach physician
diagnosis or laboratory evidence
of immunity as applicable

I certify that the immunization dates are true to the best of my knowledge

Validating Signature	Title	Date
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*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 Normal Limits	Under Care	Referred			Within Normal Limits	Under Care	Referred
Vision Tested?	<input type="checkbox"/> Visual Activity				Urinalysis Done?	<input type="checkbox"/> Sugar			
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muscle Imbalance				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Albumin			
Date _____	<input type="checkbox"/> Other _____ (Specify)				Date _____	<input type="checkbox"/> Microscopic			
Hearing Tested?	<input type="checkbox"/> Audiometer				Blood Pressure Measured?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other _____ (Specify)				<input type="checkbox"/> Yes <input type="checkbox"/> No				
Date _____					Reading _____				
Hemoglobin/Hematocrit Tested?					Height _____ Weight _____				
<input type="checkbox"/> Yes <input type="checkbox"/> 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 six living in high risk areas should be tested at the same intervals as noted above.				
<input type="checkbox"/> Yes <input type="checkbox"/> No									
Date _____	Result _____								

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 for treatment:

Dentist's Signature

Date

COMMENTS