# HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections 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) Date of Birth: ____/____/____

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Today's Date: ____/____/____

Parent/ Guardian: _____ (Last) _____ (First) _____ (Middle) Telephone: (____) _____ (Home)

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Telephone: (____) _____ (Work)

## SECTION I – HEALTH HISTORY

| Yes | No | Resolved | # Is your child having any of the problems listed below? |
|---|---|---|---|
| ☐ | ☐ | ☐ | 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 Exam: ____/____/____ |
| ☐ | ☐ | ☐ | Other (please describe): _____ |
| ☐ | ☐ | | Does your child take any medication(s) regularly? |

Reason for medication:

_____ ____/____/____
*Parent/Guardian Signature* *Date*

**Birth History:**

Are there any current or past diagnosis(es): ☐ Yes ☐ No

If yes, please describe

If yes, list medications: →

Was the health history reviewed by a health professional?
☐ Yes ☐ No *Examiner's Initials:* _____

## SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

| No | Yes | Was child tested for: | Test results: | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | VISION Date: ____/____/____ | Visual Acuity | | | |
| | | | Muscle Imbalance | | | |
| | | | Other: | | | |
| ☐ | ☐ | HEARING Date: ____/____/____ | Audiometer | | | |
| | | | Other: | | | |
| ☐ | ☐ | URINALYSIS Date: ____/____/____ | Sugar | | | |
| | | | Albumin | | | |
| | | | Microscopic | | | |
| ☐ | ☐ | BLOOD LEAD LEVEL Date: ____/____/____ | Level: _____ µg/dL → | | | |

| No | Yes | Was child tested for: | Test Results: | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | HEIGHT & WEIGHT | Height: _____ | | | |
| | | | Weight: _____ | | | |
| ☐ | ☐ | Other: | Other: _____ | | | |
| ☐ | ☐ | HEMOGLOBIN / HEMATOCRIT | → | | | |
| ☐ | ☐ | BLOOD PRESSURE | Reading: _____ | | | |
| ☐ | ☐ | TUBERCULIN Date: ____/____/____ | Type: _____ Neg.: ☐ Pos.: ☐ _____mm | | | |

**NOTE:** Blood lead level required 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 listed above.

### Examinations and/or Inspections

Essential Findings Deviating from Normal:

**Exam Date:** ____/____/____

## SECTION III – 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.*

| VACCINES | DATE ADMINISTERED MM/DD/YYYY | |
|---|---|---|
| Hepatitis B (Hep B) | 1 | 3 |
| | 2 | |
| DTaP/DTP/DT/Td/Tdap (Circle Type) | 1 | 5 |
| | 2 | 6 |
| | 3 | 7 |
| | 4 | 8 |
| Haemophilus Influenzae type b (HIB) | 1 | 3 |
| | 2 | 4 |
| Polio – IPV / OPV (circle type) | 1 | 3 |
| | 2 | 4 |
| Pneumococcal Conjugate (PCV7) | 1 | 3 |
| | 2 | 4 |
| Rotavirus (Rota) | 1 | 3 |
| | 2 | |
| Measles, Mumps, Reubella (MMR) | 1 | 2 |
| Varicella (Chickenpox) | 1 | 2 |

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

| VACCINES | DATE ADMINISTERED MM/DD/YYYY | |
|---|---|---|
| Hepatitis A (Hep A) | 1 | 2 |
| Influenza TIV/LAIV | 1 | 3 |
| | 2 | 4 |
| Meningococcal MCV4 / MPSV4 | 1 | 2 |
| Human Papillomavirus (HPV) | 1 | 3 |
| | 2 | 4 |

| OTHER Vaccines: Specify Date & Type | Type of Vaccine(s) | Date of Vaccine(s) |
|---|---|---|
| | 1 | |
| | 2 | |
| | 3 | |

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

*NOTE: According to Public Act 368 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 the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

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

_____ _____ ____/____/____

***Health Professional's Signature*** Title Date

## SECTION IV – RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain: |
| ☐ | ☐ | Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other: |

Other Recommendations:

## SECTION V – DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ____/____/____

***Dentist's Signature*** Date

## PHYSICIAN'S SIGNATURE

_____ ____/____/____ _____ _____

***Examiner's Signature*** Date Examiner's Name (print or type) Degree or License

_____ _____ MI _____ (____) _____

Number & Street City ZIP Code Telephone:

Information required for:

***Early On®*** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** – Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health; Michigan American Association of Pediatrics; Early Childhood Investment Corporation; Child Care Licensing, Head Start, Michigan State Medical Society; Michigan Association of Osteopathic Physicians and Surgeons