Developed in Co-operation With:
Departments of Social Services,
Public 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 YOU 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, medication, 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 _____

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
DTP/DT/Td (Specify Type) DIPHTHERIA TETANUS		1	Mo/Day/Yr:
		2	Mo/Day/Yr:
		3	Mo/Day/Yr:
		4	Mo/Day/Yr:
		5	Mo/Day/Yr:
		6	Mo/Day/Yr:
		7	Mo/Day/Yr:
Haemophilus influenzae type b		1	Mo/Day/Yr:
Haemophilus influenzae type b		2	Mo/Day/Yr:
POLIO (Specify Type) OPV/IPV		1	Mo/Day/Yr:
		2	Mo/Day/Yr:
		3	Mo/Day/Yr:
		4	Mo/Day/Yr:
		5	Mo/Day/Yr:
Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated			
Measles		1	Mo/Day/Yr:
Rubella		1	Mo/Day/Yr:
Mumps		1	Mo/Day/Yr:
Chickenpox		1	Mo/Day/Yr:
OTHER VACCINES			
Indicate physician diagnosis of disease 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 _____

*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:			

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 to treatment: _____

_____ Dentist's Signature _____ Date

COMMENTS: