HEALTH APPRAISAL

ear Parent or Guardian:
e 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 equested 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		
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: _____

arent 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:
DTP/DT/Td (Specify Type)		1.		6.
		2.		7.
		3.		8.
		4.		9.
		5.		10.
POLIO (Specify Type) OPV/IPV		1.		4.
		2.		5.
		3.		
Haemophilus influenzae type b		1.		3.
		2.		4.

Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated.

	Mo./Day/Yr:	Mo./Day/Yr:
MMR	1.	2.
Hepatitis B	1.	3.
	2.	
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