HEALTH APPRAISAL

Developed in Cooperation With:
Departments of Social Services,
Public Health, and Education;
Michigan State Medical Society;
Michigan Association of Osteopathic Physicians and Surgeons

☐ 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 (Last / First / Middle) Sex Date of Birth

Address (Number & Street / City / Zip) Today's Date

Parent's or Guardian's Name (Last / First / Middle) Telephone (Home)

Address (Number & Street / City / Zip) Telephone (Work)

SECTION I – HEALTH HISTORY

Is your child having any of the problems listed below?	YES	NO
1. Allergies of 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

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:		DATE ADMINISTERED	
OTP/OT/Td (Specify Type)	Type	Mo/Day/Yr:	Mo/Day/Yr:
		1.	6.
		2.	7.
		3.	8.
		4.	9.
		5.	10.
Polio (Specify Type) OPV/IPV		1.	4.
		2.	5.
		3.	
Haemophilus Influenza 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.			
MMR			
Hepatitis B		1.	3.
		2.	
OTHER VACCINES			
Indicate physician diagnosis of disease or laboratory evidence of immunity as applicable			
VACCINES WAVED DUE TO REACTIONS/CONTRADICATIONS/ RELIGIOUS OBJECTIONS			
I certify that the immunization dates are true to the best of my knowledge.			
Validating Signature		Title	Date

According to Act 358, Public Acts of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exceptions to these requirements are granted to medical, religious, and other objections provided that waiver forms are properly prepared, signed, and delivered to school administration. Forms for these exemptions are available at your school or local health department.

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS
EXAMINATION 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	☐ Audiometer ☐ Other				Blood Pressure Measured? ☐ Yes ☐ No Reading				
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No					Height _____ Weight _____ Other:				
ESSENTIAL FINDING DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS _____									
DOCTOR'S/NURSE'S SIGNATURE DATE:									

Tuberculin Test (if given) Date _____ Type: _____ ☐ Negative ☐ Positive _____ mm.

SECTION IV- RECOMMENDATIONS

Is there any defect of vision, hearing, or other conditions 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 _____ teeth and make the following recommendations as to treatment: _____
Child's Name

Dentist's Signature Date

COMMENTS: