## 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.)

PERS														
Child's	ş N	ame:	Last						Frst	Middle	Date of Birth:/	/		_
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Addre	55:	Number & Str	eel					-City	MI	IP Code	Today's Date:/_	/		
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Guard	ian		Last						First	Midale	Telephone: ()	115-0		
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<b>.</b> .		# # Is your shild brying on												1
Yes	운	# Is your child having an	y of the problems listed below?			,	Birtir	ı His	story:					
a			(for example, food, medicalion or othe	er)		-								
0		<ul> <li>2 Hay Fever, Asthma, or</li> </ul>				-								
	_	3 Eczema or Frequent SI			$\exists$									
		☐ 4 Convulsions/Seizures			$\neg$	$\vdash$								
	드 ㅁ	5 Heart Trouble		<del>-</del>		-								
l					$\dashv$	-								
	9					-						·		
	_		hroats, Earaches (4 or more per year	')					any current or past diagnosis(	es): 🗆 `	Yes □ No			
·····	<u> </u>	8 Trouble with Passing U	rine or Bowel Movements		_	-	f yes	, ple	ease describe					
		9 Shortness of Breath			_	-								$\neg$
0 1		☐ 10 Speech Problems				L								
		☐ 11 Menstrual Problems										·		
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la 1		Other (please describe):												-1
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0 (	J	Does your child take any m	edication(s) regularly?				If yes	s, lis	t medications:			***************************************		
Reasi	ดก	for medication:			- ا	<b>&gt;</b>								
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		Parent/Guardian Sigr	nature Date			$\perp$		ΟY	'es □No E	xaminer's Ini	itials:			
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		SEC	CTION II - PHYSICAL EXAMIN	IA.		N, II	NSF	ec.	TION, TESTS AND MEA	SUREMEN	TS			
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No Ye	s,	Was child tested for:	Test results:	ž į	ŭ	5	No.	Yes	Was child tested for:	Tes	t Results:	5	Ref	5
_ _		VISION	Visual Acuity			ļ			HEIGHT & WEIGHT	Heig	pht:	T	Т	$\top$
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		HEARING	Audiometer		1	ł	Ш	u	HEMOGLOBIN / HEMATOCR	IT J	<b>→</b>	7		Ī.,
		Date:/	Other:			٠	Οį	$\sigma_1$	BLOOD PRESSURE	⊦Read	Reading:			
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	1	URINALYSIS	Sugar	<u>i</u>				٦	TUBERCULIN	Туре		1		
Ì		Dae:/_/	Albumin Microscopic	···i			<u></u>	j	Date:	i Neg.:	: 🗇 Pos.: 🗇	mm		
	_	BLOOD LEAD LEVEL			- 1	7	HOT	Ē: E	Blood lead level required for all	children enrol	led in Medicaid must be tee	lad at	200	and
	•		Level:ng/dL		<b>→</b>		IVU I	чеаг.	'5 Of 208, of once between thre	e and civ vesi	re of ago if pot occiously to		K 11	
	:	Dat:/				1	abov	/e <u>.                                    </u>	under age six living in high-risk	careas should	l be lesled at the same inte	vals as	s liste	ed
	_		Exam	ina	tion	s a	nd/c	or In	spections					
Essent	ial	Firdings Deviating from Normal:		_	_	_								$\neg$
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											Exam Date: 1	,		

VACCINES	C TO DATE 6	OF COMPLETE" will not be ac DATE ADMINISTERED	ccepted. Admission to school may be der	nied on the basis of this	nformation.*
TATOMES	-	MM/DD/YYYY	VACCINES	DATE AD	MINISTERED DO/YYYY
Hepatitis B (Hep B)	2	3	Hepatitis A (Hep A)	1	2
	1		Influenza TIV/LAIV	1	3
DTaP/DTP/DT/Td/Tdap	2	5   6		2	4
(Cineta T)	3	7	Meningococcal MCV4 / MPSV4		2
(Circle Type)	4	8	Human Papillomavirus (HPV)	1	3
Haemophilus Influenzae	1	3		2	4
lype b (HIB)	2	4	OTHER Vaccines:	Type of Vaccine(s)	Date of Vaccine(s
Polia – IPV / OPV	1	3	Specify Date & Type	1	
(circle type)	2	4	Specify Date & Type	3	
Pneumococcal Conjugate (PCV7)	1	3	Indicate and attach physician dia		<del></del>
	2	4	Indicate and attach physician diag	unusis or laboratory eviden	ce of immunity as appli
Rotavirus (Rota)	1	3	*NOTE: According to Public Act 3		
rolavius (rusa)	2				
Measles, Mumps, Reubella (MMR)	1	2			
		2	your child's school admit		exemptions are availab
listory of Chickenpox Disease? 🛘 Yes	s ∏ No. If yor	dato:			
		The state of the s	Parent/Guardian refused immuniz	ations:	
certify that the immunization dates are	true to the best of	my knowledge:			
Hoalth	Professional's Sig			1	1
Treatti	riviessional's Sig	qnature	Title	Date	· <del></del>
O Yes	1earing or other con	(Required for Child	V — RECOMMENDATIONS Care and Head Start/Early Head Start) I help by seating or other actions? If yes, ple	ease explain:	
Should the child's activity be r	hearing or other con	(Required for Child	Care and Head Start/Early Head Start)  I help by seating or other actions? If yes, ple		ts □ Other:
Should the child's activity be r	hearing or other con	(Required for Child	Care and Head Start/Early Head Start)  I help by seating or other actions? If yes, ple		ts ☐ Other:
Is there any defect of vision, the street of the stre	hearing or other con	(Required for Child	Care and Head Start/Early Head Start)  I help by seating or other actions? If yes, ple		ts 🗖 Other:
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Is there any defect of vision, h	restricted because of restriction (s):	(Required for Child idition for which the school could of any physical defect or illness? ☐ Classroom ☐ Playgrou	Care and Head Start/Early Head Start)  I help by seating or other actions? If yes, planting or other actions? If yes, planting the control of	ol 🗇 Competitive Spor	ts 🖸 Other:
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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.

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