



**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		VACCINES	DATE ADMINISTERED MM/DD/YYYY				
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2			
	2		Influenza TIV/LAIV	1	3			
DTaP/DTP/DT/Td/Tdap  (Circle Type)	1	5	2	4	Meningococcal MCV4 / MPSV4	1	2	
	2	6	Human Papillomavirus (HPV)	1	3	OTHER Vaccines: Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	3	7		2	4		1	
	4	8			2			
Haemophilus influenzae type b (HIB)	1	3			3			
Polio – IPV / OPV (circle type)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.</i> *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.					
	2	4						
Pneumococcal Conjugate (PCV7)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>					
	2	4	I certify that the immunization dates are true to the best of my knowledge:  _____ Health Professional's Signature Title / Date					
Rotavirus (Rota)	1	3						
	2							
Measles, Mumps, Reubella (MMR)	1	2						
Varicella (Chickenpox)	1	2						
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, 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: \_\_\_\_\_

Dentist's Signature / Date

**PHYSICIAN'S SIGNATURE**

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

Number & Street / City / MI / 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.

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