Developed in Cooperation With:

Department of Human Services
Departments of Community 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 (111, IV, V) are to be completed by a doctor, nurse, and dentist. (BE SURE TO BRING YOUR 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. Convulsions/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 medications regularly? ☐ Yes ☐ No

If yes, what medication?

Reason for Medication:

Parent's Signature: _____

SECTION II –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 Type	Mo/Day/Yr.	Type	Mo/Day/Yr.
Hepatitis B (Hep B)	1		3	
	2			
DTaP/DTP/DT/Td/Tdap (Specify Type)	1		5	
	2		6	
	3		7	
	4		8	
Haemophilus Influenza type b (HIB)	1		3	
	2		4	
Polio (IPV/OPV) (Specify Type)	1		3	
	2		4	
Pneumococcal Conjugate (PCV7)	1		3	
	2		4	
Rotavirus (RV)	1		3	
	2			
Measles, Mumps, Rubella (MMR)	1		2	
Varicella (Chickenpox)	1		2	
History of Chickenpox Disease? ☐ Yes ☐ No If yes, Date:				
Hepatitis A (Hep A)	1		2	
Influenza TIV/LAIV	1		3	
	2		4	
Meningococcal MCV4/MPSV4 (Specify Type)	1		2	
Human Papillomavirus HPV4	1		3	
	2			
Other Vaccines: (Specify Date & Type)				

Indicate and attach physician diagnosis 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

	Within Normal Limits	Under Care	Referred		Within Normal Limits	Under Care	Referred
Vision Tested? ☐ Yes ☐ No Date_____ ☐ Visual Activity ☐ Muscle Imbalance ☐ Other (Specify)_____				Urinalysis Done? ☐ Yes ☐ No Date_____ ☐ Sugar ☐ Albumin ☐ Microscopic			
Hearing Tested? ☐ Yes ☐ No Date_____ ☐ Audiometer ☐ Other (Specify)_____				Blood Pressure Measured? ☐ Yes ☐ No Reading_____			
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No				Height_____ Weight_____ Other:			
Blood Lead Level Tested? ☐ Yes ☐ No Date_____ Result _____				Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high risk areas should be tested at the same intervals as noted above.			

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

Providence Park Pediatrics
26850 Providence Parkway - Suite 455
Novi, MI 48374
248 465-4847
248 465-4809 fax

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 for treatment:
Child's Name

Dentist's Signature | Date

COMMENTS