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 II 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.)

CHILD'S NAME (Las	t, First, Middle)								DATE OF BIRTH (mr	n/dd/y	y)		
1000000									/	/			
ADDRESS (Number & Street) (City)							(ZIP Cod		TODAY'S DATE (mm/dd/yy)				
PARENT/GUARDIAN (Last, First, Middle)								MI		/ /			
TARENT COALDIAN	(Last, Frat, Mid	ale)			HOME TELEPHONE	NUME	3ER						
ADDRESS (Number & Street) (City)								(ZIP Cod	()	NII IN AT	SED.		
(Oity)						MI	()	WORK TELEPHONE NUMBER					
		SECTION	ON	1 -	ше	AI	TU	HISTORY			—	—	
		JEO II	OIN	-	nic.	AL	<u> </u>	HISTORT					
No Yes Resolved	s your child h	naving any of the problems listed	Birth History:										
		actions (for example, food, medic	٦.										
		hma, or Wheezing											
□ □ □ 3 Eczema or Frequent Skin Rashes													
	convulsions/S	eizures											
□ □ □ 5 Heart Trouble													
	iabetes		4										
□ □ 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)								Are there any current			No		
□ □ □ 8 Trouble with Passing Urine or Bowel Movements								If yes, please describe	<u> </u>				
□ □ 9 Shortness of Breath □ □ □ 10 Speech Problems													
	Menstrual Pro												
		ns: Date of Last Exam /											
□ □ 12 Dental Problems: Date of Last Exam / / □ □ Other (please describe):													
·									<u> </u>				
		ke any medication(s) regularly?		-				If yes, list medications	9:				
Reason for Me	Reason for Medication												
<u> </u>		····					\bot		····				
Don	Parent/Guardian Signature Date							Was the health history reviewed by a health professional? ☐ Yes ☐ No Examiner's initials:					
7 474									Examiner's Initials:		=	<u> </u>	
	SECT	ION II - PHYSICAL EXAMINA Required for Child (ATI (Car	ON, e al	, IN nd I	SP Hea	EC ad S	TION, TESTS AND M I Start / Early Head Start	EASUREMENTS t				
								ements					
			Π							$\overline{}$	Т		
			E E	重	nder Care					-	fermend	der Care	
울 🖇 Was child t	ested for:	Test results:	Nor	Referred	<u>\$</u>	٤	竁	Was child tested for:	Test results:	Mormal	Par Par	Unde	
VISION		Visual Acuity						HEIGHT & WEIGHT	Height		+	\top	
		Muscle Imbalance							Weight		T	†	
Date:	<u>'</u>	Other:						Other:	Other		1		
HEARING		Audiometer	L	L	Ш			HEMOGLOBIN / HEMATOCRIT	⇒		$oldsymbol{\mathbb{I}}$		
	, ,	Other:	<u> </u>		Ш			BLOOD PRESSURE					
URINALYSIS			-	<u> </u>	Н					_		,	
		Sugar	-	-	Н			TUBERCULIN	Type:	_			
Date:		Microscopic	-	-	-			Date: / /	Mari II D. II				
BLOOD LEAD	LEVEL	шысосоро	Ь		Н	NC.	TF-		Neg.: □ Pos.: □ mm r all children enrolled in Medicaid r			-41	
level ug/dl 🖒 at o				one	and two years of age, or o	once between three and six vears	ofac	de if	not				
Date: / / at the same intervals as listed about									r age six living in high-risk areas sh	ould b	e te:	sted	
Examinations and/or Inspections													
Essential Findings Deviating from Normal:													
MDHHS/BCAL 2204		0005/000 0005		_		_			Exam Date: /	_/	_		

PERSONAL

Statements such as "U	P-TO-DATE" or "COMI		IMMUNIZATIONS oted. Admission to school may be denied	on the basis of this info	ormation,*					
VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY						
Hepatitis B	1	3	Hepatitis A (HepA)	1	2					
(HepB)	2		1-finan- (13/4 ADA	1	3					
	1	4	Influenza (IIV/LAIV)	2	4					
DTaP/DTP/DT/Td	2	5	Meningococcal (MCV4 / MPSV4)	1	2					
	3	6	Human Papillomavirus	1	3					
Tdap	1		(HPV9/HPV4/HPV2)	2						
Haemophilus Influenzae	1	3		Type of Vaccine(s)	Date of Vaccine(s)					
type b (HIB)	2	4	OTHER Vaccines	1						
Polio	1	3	Specify Date & Type	2	<u> </u>					
(IPV/OPV)	2	4		3						
Pneumococcal Conjugate	1	3	Indicate and attach physician diagnosis	or laboratory evidence of	immunity as applicable					
(PCV7/PCV13)	2	4	*NOTE: According to Public Act 368 of 1							
Rotavirus (RV1/RV5)	1	3	the first time must be adequately	v immunized, vision teste	d and hearing tested.					
	2	 	Exemptions to these requirement	its are granted for medical	al. religious and other					
Measles, Mumps, Rubella (MMR)	1	2	objections, provided that the wa delivered to school administrato	liver forms are properly pi irs. Forms for these exem	repared, signed and options are available					
Varicella (Chickenpox)	1	2	at your provider office for medica	al walver forms and throug						
History of Chickenpox Disease? ☐ Yes		1-	department for nonmedical waiver forms. Parent/Guardian refused immunizations:							
I certify that the immunization dates are tr		edae		-	·					
		- -5 -			1 1					
Health i	Professional's Signatu	re	Title		Date					
	······································									
SECTION IV - RECOMMENDATIONS 용 일 (Required for Child Care and Head Start/Early Head Start)										
	ing or other condition for y	vhich the school could help t	by seating or other actions? If yes, please explain	n:						
		<u> </u>	· · · · · · · · · · · · · · · · · · ·		-					
Should the child's activity be rest	ricted because of any phys	sical defect or illness?		<u> </u>						
If yes, check and explain degree			Gymnasium 🛘 Swimming Pool 🗘 Compet	itive Sports Other						
		<u> </u>								
Other Recommendations				·						
	SECTION V - DEN	ITAL EXAMINATION	AND RECOMMENDATIONS (OPTI	ONAL)						
I have examined		's teeth A	s a result of this examination, my recommendati	On for treatment is:						
child's name										
										
	Dentist's Signature	•		Date /						
PHYSICIAN'S SIGNATURE										
Examiner's Signatu	178	Date	Examiner's Name (Prin	t or Time)	Degree or License					
					Degree of License					

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 well-child care visit 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 Department of Health and Human Services, Education, 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.