Developed in Cooperation With:	APPRAISAL		☐ School				
Department of Human Services				Children's	•		
Departments of Community Health, and Education;						Child Care	
Michigan State Medical Society; Michigan Association of Osteopathic Physicians and	d Surgeon	9				☐ Child Caring ☐ Other:	institution
Dear Parent or Guardian: The following information is requeste	d so that the	school and parent	can work together to me	et the physical.	intellectual.	and emotional nee	ds of the child. Fill
out the information requested in Section I. Section II may be cer completed by a doctor, nurse, and dentist. (BE SURE TO BRING	tified by tran	scription of informa	ation from the certificate of	f immunization	. The remain	ning sections (111,	IV, V) are to be
PERSONAL	<u> </u>	125 0 11111101112711			,		
Child's Name				Sex		Date of Birth _	
Last Address		First	ľ	Middle		Today's Data	
Number & Street			City		Zip	roday 3 Date_	
Parent's or Guardian's Name		Fi d		Middle		Telephone (Home) _	
Last Address		First	ľ	vildale		Telephone (Work)	
Number & Street			City		Zip		
SECTION I HEALTH HISTORY		1	SECTION II –IMN Statements such as "UP			uill not be accepted. A	dmission to school
Is your child having any of the problems listed below?	Yes	No	may be denied on the ba	asis of this inform	ation. *	•	amission to school
1. Allergies or reactions: (for example, food, medication, or other)			VACCINES	Туре	<b>DAT</b> Mo/Day/Yr.	TE ADMINISTERED Type	Mo/Day/Yr.
2. Hay fever, asthma, or wheezing			Hepatitis B (Hep B)	1		3	
Eczema or frequent skin rashes				2			
4. Convulsions/Seizures			DTaP/DTP/DT/Td/Tdap	1		5 .	
5. Heart trouble			(Specify Type)				
6. Diabetes				2		6 .	
Frequent colds, sore throats, earaches				3 .		7 .	
(4 or more per year)			11	4		8	
8. Trouble with passing urine or bowel movements			Haemophilus Influenza type b	1 .		3	
9. Shortness of breath			(HIB)	2		4	
10. Speech problems			Polio (IPV/OPV) (Specify Type)	1 .		3 .	
11. Menstrual problems				2 .		4	
12. Dental problems: date of last examination:			Pneumococcal Conjugate (PCV7)	1		3	
13. Other			, ,	2		4	
			Rotavirus (Rota)	1		3	
				2			
Please explain any problem areas identified above:			Measles, Mumps, Rubella (MMR)	1		2	
			Varicella (Chickenpox)	1 .		2	
			History of Chickenpox		Yes 🗖 No		
			Hepatitis A (Hep A)	1		2	
			Influenza	4			
			TIV/LAIV	1		3	
			Meningococcal	2		4	
			MCV4/MPSV4 (Specify Type)	1		2	
			Human Papillomavirus	1		3	
			HPV	2		4	
			Other Vaccines:				
			(Specify Date & Type)				
			Indicate and attach phys	ician		•	
			diagnosis or laboratory e of immunity as applicable				
Does your child take any medications regularly?  If yes, what medication?  Reason for Medication:	Yes □ No		I certify that	the immunization	n dates are tru	ue to the best of my kn	owledge
Parent's Signature:							

Validating Signature

Title

Date

<sup>\*</sup>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** 

Care	Within   Normal   Carle   Referred   Referred Referred   Referred Referr	ESSENTIAL FINDINGS DEVIATING FROM NO								
Normal Care	Within   Normal Care   Norma									
Within   Normal   Care   Referred   Within   Care   Referred   R	Wilhin   Worder   Normal   Care   Normal   C									
Normal Care	Within   Normal Care   Norma									
Normal   Normal Care   Norma	Within   Normal   Care   Nor			TESTS AN	ND MEASURE!	MENTS				
Visual Activity   Visual None?   Sugar   Visual Activity   Visual None   Vis	Visual Activity   Urinalysis Done?   Sugar		Normal	Under				Normal		Referre
Learing Tosted?   Date   Date	Tuberculin Test (if given)  Date   Date   Microscopic   Mi	/ision Tested?	Limito			Urinalysis Done?	☐ Sugar	Lillito		
tearing Tested?   Guidometer   Blood Pressure Measured?   George   George	tearing Tested?   Gloudemeter   Blood Pressure Measured?   Gloudemeter	] Yes ☐ No ☐ Muscle Imbalance				☐ Yes ☐ No	Albumin			
Blood Pressure Measured?	Blood Pressure Measured?	Date Other				Date	☐ Microscopic			
Reading	Reading					Blood Pressure Measur	ed?			
Reading   Read	Reading					☐ Yes ☐ No				
Other:	Other:					Reading				
Other:	Other:	lemoglobin/Hemotocrit Tested?				Height	Weight			
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 in for previous tested. All children under age six living in high risk areas should be tested at the same intervals as noted above.    SSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS	Blood Lead level Tested?    Ves						- 3			
with the student's activity be restricted because of any physical defect or lilness?   Yes   No   If yes, check below and explain degree of restriction:   Camp   Other	Tuberculin Test (if given) Date					Blood Lead level recom				
six living in high risk areas should be tested at the same intervals as noted above.    Security	six living in high risk areas should be tested at the same intervals as noted above.    Six living in high risk areas should be tested at the same intervals as noted above.	] Yes □ No	must be tested at one and two years of age, or once between				en three			
Tuberculin Test (if given)  Date	ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS  Tuberculin Test (if given) Date	Date Result				six living in high risk are	eas should be tested at	the same int	ervals	
Tuberculin Test (if given) Date	Tuberculin Test (if given)  Date									
hould 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      Available of 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	hould 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      Available of 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	ECTION IV RECOMMENDATIONS								
hould 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      Xaminer's Signature   Date   Examiner's Name (print or type)   Degree or License	hould 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		which the school co	ould help by s	seating or other ac	tion? Yes No				
Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp Other    Camp Other Camp Other	Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp Other    Camp Other Camp Other Camp Other Camp Camp Other Camp Other Camp Camp Other Camp Camp Other Camp Camp Other Camp Camp Camp Other Camp Camp Other Camp Camp Other Camp Camp Camp Other Camp Camp Other Camp Camp Camp Other Camp Camp Camp Camp Other Camp Camp Camp Camp Camp Camp Camp Camp	уез, рісазе ехріані.								
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xaminer's Signature Date Examiner's Name (print or type) Degree or License umber & Street City Zip Telephone  EECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date	xaminer's Signature Date Examiner's Name (print or type) Degree or License umber & Street City Zip Telephone  EECTION V DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)  have examined teeth and make the following recommendations as for treatment:  Child's Name  Dentist's Signature Date	hould the student's activity be restricted because of any p	physical defect or illi	ness? 🔲 Ye	es 🗌 No If yes,	check below and explain degre	e of restriction:			
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	Dentist's Signature Date				teeth a	and make the following recomm	endations as for treatment:			
•	•	Child's Name								
•	•									
•	•									
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							Dentist's Signature		Date	
		OMMENTS					Dentist's Signature		Date	
		OMMENTS					Dentist's Signature		Date	