HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**).

PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2	Anaphylaxis	
☐	☐		3	Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5	Eczema or Frequent Skin Rashes	
☐	☐	☐	6	Convulsions/Seizures	
☐	☐	☐	7	Heart Trouble	
☐	☐	☐	8	Diabetes	
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____	
☐	☐	☐		Other (please describe) _____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? ☐ Yes ☐ No **Examiner's Initials** ____

SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS
Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
☐	☐	Hearing Date _____	☐ Audiometer (R= Right, L=Left)	R/L	R/L	
			☐ OAE (R= Right, L=Left)	R/L	R/L	
			☐ Other (R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar			
			Albumin			
			Microscopic			
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl			
Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.						
☐	☐	Height & Weight	Height			
			Weight			
		Other _____	Other _____			
☐	☐	Hemoglobin/Hematocrit	⇨			
☐	☐	Blood Pressure	Reading _____			

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

Examinations and/or Inspections

Essential Findings Deviating from Normal
Exam Date _____

SECTION III – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*****

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additonal Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		

I certify that the immunization dates are true to the best of my knowledge		
Health Professional's Signature	Title	Date

SECTION IV – RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received ☐ Dental Exam	☐ Dental Assessment
Findings and Recommendation (Check all that apply) ☐ No Urgent Needs	☐ Routine Care Needed	☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care	☐ Untreated Decay	☐ Further Referral for Specialist
Signature		Date
Check One ☐ Dentist	☐ Dental Therapist	☐ Dental Hygienist

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.