

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 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 and dentist. **(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 MI / /
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	WORK TELEPHONE NUMBER ()
	(ZIP Code) MI	

SECTION I - HEALTH HISTORY

<p>Is your child having any of the problems listed below?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Resolved <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 Allergies or Reactions (for example, food, medication or other)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 Hay Fever, Asthma, or Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 3 Eczema or Frequent Skin Rashs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4 Convulsions/Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 5 Heart Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6 Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 8 Trouble with Passing Urine or Bowel Movements</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9 Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 10 Speech Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 11 Menstrual Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 12 Dental Problems: Date of Last Exam / /</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (please describe): _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Does your child take any medication(s) regularly?</p> <p>Reason for Medication _____</p> <p>Parent/Guardian Signature _____ / / Date</p>	<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe: _____</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list medications: _____</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
---	---

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements			
Was child tested for:	Test results:	Normal	Referred
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> VISION	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>
	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Date: / /	Audiometer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> HEARING	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Date: / /	Sugar	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> URINALYSIS	Albumin	<input type="checkbox"/>	<input type="checkbox"/>
Date: / /	Microscopic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> BLOOD LEAD LEVEL	Level _____ ug/dl	<input type="checkbox"/>	<input type="checkbox"/>
Date: / /		<input type="checkbox"/>	<input type="checkbox"/>

Was child tested for: HEIGHT & WEIGHT Test results: Height _____ Weight _____
 Other: _____ Other: _____
 HEMOGLOBIN / HEMATOCRIT Reading: _____
 BLOOD PRESSURE Type: _____
 Date: / / Neg.: Pos.: mm

NOTE: Blood lead level required 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 listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /
