

# 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)	TODAY'S DATE (mm/dd/yy) / /
			MI
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ( )
			MI

## SECTION I - HEALTH HISTORY

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

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height				
			Muscle Imbalance							Weight				
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE TUBERCULIN	Reading: _____				
			Other: _____							Type: _____				
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	Date: / /	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm				
			Albumin											
			Microscopic											
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl						<b>NOTE:</b> 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: / /

**SECTION III - 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 (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			Influenza (IIV/LAIV)	1
DTaP/DTP/DT/Td	1	4	2		4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6		2	
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus influenzae type b (HIB)	1	3		2	Type of Vaccine(s)
	2	4	OTHER Vaccines		
Polio (IPV/OPV)	1	3	Specify Date & Type		
	2	4	1		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	2		
	2	4	3		
Rotavirus (RV1/RV5)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2		*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.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:					
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)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

**SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)**

I have examined \_\_\_\_\_'s teeth. As a result of this examination, my recommendation for treatment is: \_\_\_\_\_  
child's name

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Dentist's Signature Date

**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Examiner's Signature Date Examiner's Name (Print or Type) Degree or License

\_\_\_\_\_ MI \_\_\_\_\_  
 Number & Street City ZIP Code Telephone

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.

**This form must be submitted to  
Ada Christian School  
by the first day of school along with the  
health appraisal form.**

*Ada Christian School*

**Consent for Disclosure of Personally Identifiable Information and Immunization Information to  
Local and State Health Departments**

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information and immunization information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

---

*I authorize Ada Christian School to release my child's immunization record and personally identifiable information to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name: \_\_\_\_\_ Date of Birth:   /  /  

Signature of Parent/Guardian  
or Eligible Student: \_\_\_\_\_ Date:   /  /  

Printed Parent/Guardian Name: \_\_\_\_\_

