Developed in Cooperation With:
Departments of Consumer and Industry Services
Community Health, and Education;
Michigan State Medical Society;
Michigan Association of Osteopathic Physicians and Surgeons

HEALTH APPRAISAL

☐ School
☐ Children's Group
☐ Child Care Center
☐ Child Caring Institution
☐ Other: ______

Dear Parent or Guardian:
The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section I. Section II may be certified by transcription of information from the certificate of immunization. The remaining sections (III, IV, V) are to be completed by a doctor, nurse, and dentist. (BE SURE TO BRING YOU CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)

PERSONAL

Child's Name ______ (Last / First / Middle) Sex ______ Date of Birth ______

Address ______ (Number & Street / City / Zip) Today's Date ______

Parent's or Guardian's Name ______ (Last / First / Middle) Telephone (Home) ______

Address ______ (Number & Street / City / Zip) Telephone (Work) ______

SECTION I — HEALTH HISTORY

Is your child having any of the problems listed below?	YES	NO
1. Allergies or reactions: (For example, food, medication, or other)		
2. Hay fever, asthma, or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsion/Seizures		
5. Heart trouble		
6. Diabetes		
7. Frequent colds, sore throats, earaches (4 or more per year)		
8. Trouble with passing urine or bowel movements		
9. Shortness of breath		
10. Speech problems		
11. Menstrual problems		
12. Dental problems. Date of last examination		
13. Other		

Please explain any problem areas identified above:

Does your child take any medication regularly? ☐ YES ☐ NO

If yes, what medication? ______

Reason for medication: ______

Parent's Signature: ______

SECTION II — IMMUNIZATION

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

VACCINE:	TYPE	DATE ADMINISTERED Mo/Day/Yr:	TYPE	Mo/Day/Yr:
DTP/DT/Td DTaP (Specify Type)		1.		6.
		2.		7.
		3.		8.
		4.		9.
		5.		10.
Haemophilus influenzae type b (HIB)		1.		3.
		2.		4.
POLIO (Specify Type) OPV/IPV		1.		4.
		2.		5.
		3.		
Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated.				
MMR		Mo/Day/Yr: 1.		Mo/Day/Yr: 2.
Varicella (Chickenpox)		1.		
		2.		
Hepatitis B		1.		3.
		2.		
Pneumococcal Conjugate (PCV)		1.		3.
		2.		4.
Other Vaccines				
Indicate physician diagnosis of disease or laboratory evidence of immunity as applicable				
VACCINES WAIVED DUE TO REACTIONS/CONTRAINDICATIONS/ RELIGIOUS OBJECTIONS				

I certify that the immunization dates are true to the best of my knowledge

Validating Signature ______ Title ______ Date ______

*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.