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: ____/____/____

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Today's Date: ____/____/____

Parent/ Guardian: _____ (Last) _____ (First) _____ (Middle) Telephone: (____) _____ (Home)

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Telephone: (____) _____ (Work)

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2	Hay Fever, Asthma, or Wheezing:
☐	☐	☐	3	Eczema or Frequent Skin Rashes
☐	☐	☐	4	Convulsions/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 Exam: ____ / ____ / ____
☐	☐	☐		Other (please describe): _____
☐	☐			Does your child take any medication(s) regularly?

Reason for medication:

_____ (Parent/Guardian Signature) ____/____/____ (Date)

Birth History:

Are there any current or past diagnosis(es): ☐ Yes ☐ No

If yes, please describe

If yes, list medications:

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

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: ____/____/____	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: ____/____/____	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: ____/____/____	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: ____/____/____	Level: _____ µg/dL →			

No	Yes	Was child tested for:	Test Results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height: _____			
			Weight: _____			
☐	☐	Other:	Other: _____			
☐	☐	HEMOGLOBIN / HEMATOCRIT	→			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: ____/____/____	Type: _____ 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: ____/____/____