

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

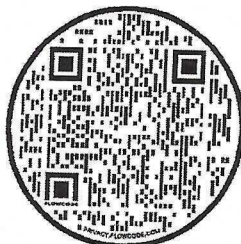
Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
<input type="checkbox"/>	<input type="checkbox"/>	Vision Date _____	Visual Acuity Muscle Imbalance Other			
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Date _____	<input type="checkbox"/> Audiometer (R= Right, L=Left) <input type="checkbox"/> OAE (R= Right, L=Left) <input type="checkbox"/> Other (R= Right, L=Left)	R/L R/L R/L	R/L R/L R/L	
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar Albumin Microscopic			
<input type="checkbox"/>	<input type="checkbox"/>	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.

<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height Weight Other _____			
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	→			
<input type="checkbox"/>	<input type="checkbox"/>	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.



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	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
	2	4		2	
Polio (IPV/OPV)	1	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	5		1	
	3			2	
				3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable. *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	4			
Rotavirus (RV1/RV5)	1	3			
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: <input type="checkbox"/>		
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	
<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): <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Classroom <input type="checkbox"/> Swimming Pool</div><div><input type="checkbox"/> Playground <input type="checkbox"/> Competitive Sports</div><div><input type="checkbox"/> Gymnasium <input type="checkbox"/> Other</div></div> _____
Other Recommendations _____ _____		

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name _____		Has received <input type="checkbox"/> Dental Exam <input type="checkbox"/> Dental Assessment
Findings and Recommendation (Check all that apply)		
<input type="checkbox"/> No Urgent Needs	<input type="checkbox"/> Routine Care Needed	<input type="checkbox"/> Treated Decay
<input type="checkbox"/> Restorative/Urgent Needs for Dental Care	<input type="checkbox"/> Untreated Decay	<input type="checkbox"/> Further Referral for Specialist
Signature _____		Date _____
Check One <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Therapist <input type="checkbox"/> 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.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:		Date of Admission		Date of Discharge	
Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Home Phone ()	Parent/Legal Guardian's Name (Optional)		Home Phone ()
Home Address (if not child's address)		Cell Phone ()	Home Address (if not child's address)		Cell Phone ()
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address		
Employer Name		Work Phone ()	Employer Name		Work Phone ()
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number ()		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)					

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse 5

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	()	()
2.	()	()
3.	()	()

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian

Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116

COMPLETION: Required

PENALTY: Rule Violation Citation.