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
			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:

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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
		HEARING	Audiometer			
			Other:			
		Date: / /				
		URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
		BLOOD LEAD LEVEL	Level _____ ug/dl			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
		HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
		HEMOGLOBIN / HEMATOCRIT				
		BLOOD PRESSURE	Reading: _____			
		TUBERCULIN	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: / /

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	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? Yes No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
In uenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (+39 HPV /HPV)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	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 rst 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 SURYLGHU RIILFH IRU PHGLFDO ZDLYHU IRUP department IRU QRQPHGLFDO ZDLYHU IRUP

Parent/Guardian refused immunizations:

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	
		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:
		Should the child s activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): Classroom Playground Gymnasium Swimming Pool Competitive Sports 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