

**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.)**

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

| Resolved                                  |                             |                          | # Is your child having any of the problems listed below?                  |   | Birth History:                                                                                                                                    |  |
|-------------------------------------------|-----------------------------|--------------------------|---------------------------------------------------------------------------|---|---------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> Yes              | <input type="checkbox"/> No | <input type="checkbox"/> | 1 Allergies or Reactions (for example, food, medication or other)         |   |                                                                                                                                                   |  |
| <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)             |   | 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"/> | 8 Trouble with Passing Urine or Bowel Movements                           |   | If yes, please describe:                                                                                                                          |  |
| <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): _____<br>_____                                   |   |                                                                                                                                                   |  |
| <input type="checkbox"/>                  | <input type="checkbox"/>    |                          | Does your child take any medication(s) regularly?                         |   | If yes, list medications:                                                                                                                         |  |
| Reason for Medication                     |                             |                          |                                                                           | ⇒ |                                                                                                                                                   |  |
|                                           |                             |                          |                                                                           |   |                                                                                                                                                   |  |
| _____<br><b>Parent/Guardian Signature</b> |                             |                          | _____<br>Date                                                             |   | Was the health history reviewed by a health professional?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> |  |

| 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                | Visual Acuity                                                                                         |        |          |            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | HEIGHT & WEIGHT         | Height                                                                                |        |          |            |
|                          |                          |                       | Muscle Imbalance                                                                                      |        |          |            |                                                                                                                                                                                                                                                                                                            |                          |                         | Weight                                                                                |        |          |            |
|                          |                          | Date: ____/____/____  | Other:                                                                                                |        |          |            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | Other: _____            | Other                                                                                 |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING               | Audiometer                                                                                            |        |          |            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | HEMOGLOBIN / HEMATOCRIT |  |        |          |            |
|                          |                          |                       | Other:                                                                                                |        |          |            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | BLOOD PRESSURE          | Reading: _____                                                                        |        |          |            |
|                          |                          | Date: ____/____/____  |                                                                                                       |        |          |            |                                                                                                                                                                                                                                                                                                            |                          |                         |                                                                                       |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | URINALYSIS            | Sugar                                                                                                 |        |          |            | <input type="checkbox"/>                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> | TUBERCULIN              | Type: _____                                                                           |        |          |            |
|                          |                          |                       | Albumin                                                                                               |        |          |            |                                                                                                                                                                                                                                                                                                            |                          |                         |                                                                                       |        |          |            |
|                          |                          | Date: ____/____/____  | Microscopic                                                                                           |        |          |            |                                                                                                                                                                                                                                                                                                            |                          | Date: ____/____/____    | Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm                |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD LEAD LEVEL      | 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. |                          |                         |                                                                                       |        |          |            |
|                          |                          | Date: ____/____/____  |                                                                                                       |        |          |            |                                                                                                                                                                                                                                                                                                            |                          |                         |                                                                                       |        |          |            |

|                                           |  |                          |
|-------------------------------------------|--|--------------------------|
| Essential Findings Deviating from Normal: |  | Exam Date:      /      / |
|                                           |  |                          |
|                                           |  |                          |
|                                           |  |                          |

| <b>SECTION III - IMMUNIZATIONS</b><br><small>Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*</small> |                                                |       |       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------|-------|
| VACCINES (Circle Type)                                                                                                                                                                        | DATE ADMINISTERED<br><small>MM/DD/YYYY</small> |       |       |
| Hepatitis B<br>(HepB)                                                                                                                                                                         | 1                                              | 3     |       |
|                                                                                                                                                                                               | 2                                              |       |       |
| DTaP/DTP/DT/Td                                                                                                                                                                                | 1                                              | 4     |       |
|                                                                                                                                                                                               | 2                                              | 5     |       |
|                                                                                                                                                                                               | 3                                              | 6     |       |
| Tdap                                                                                                                                                                                          | 1                                              |       |       |
| <i>Haemophilus Influenzae</i><br>type b (HIB)                                                                                                                                                 | 1                                              | 3     |       |
|                                                                                                                                                                                               | 2                                              | 4     |       |
| Polio<br>(IPV/OPV)                                                                                                                                                                            | 1                                              | 3     |       |
|                                                                                                                                                                                               | 2                                              | 4     |       |
| Pneumococcal Conjugate<br>(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? <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                                                                                                                    |                                                |       |       |
| _____                                                                                                                                                                                         |                                                | _____ | _____ |
| <i>Health Professional's Signature</i>                                                                                                                                                        |                                                | Title | Date  |

|                          |                          | <b>SECTION IV - RECOMMENDATIONS</b><br><small>(Required for Child Care and Head Start/Early Head Start)</small>                                                                                                                                                                 |
|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ |
|                                                                                                                              |
| _____<br><i>Dentist's Signature</i>                                                                                          |
| _____<br>Date                                                                                                                |

| PHYSICIAN'S SIGNATURE                |               |                                                 |                            |
|--------------------------------------|---------------|-------------------------------------------------|----------------------------|
| _____<br><i>Examiner's Signature</i> | _____<br>Date | _____<br><i>Examiner's Name (Print or Type)</i> | _____<br>Degree or License |
| _____<br>Number & Street             | _____<br>City | MI _____<br>ZIP Code                            | (_____) _____<br>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.

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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.