

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

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

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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: _____	

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
☐	☐	VISION Date: ____ / ____ / ____	Visual Acuity	☐	☐	☐	☐	☐	HEIGHT & WEIGHT Other: _____	Height	☐	☐	☐
			Muscle Imbalance	☐	☐	☐				Weight	☐	☐	☐
			Other:	☐	☐	☐				Other	☐	☐	☐
☐	☐	HEARING Date: ____ / ____ / ____	Audiometer	☐	☐	☐	☐	☐	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE		☐	☐	☐
			Other:	☐	☐	☐				Reading: _____	☐	☐	☐
				☐	☐	☐					☐	☐	☐
☐	☐	URINALYSIS Date: ____ / ____ / ____	Sugar	☐	☐	☐	☐	☐	TUBERCULIN Date: ____ / ____ / ____	Type: _____	☐	☐	☐
			Albumin	☐	☐	☐				Neg.: ☐ Pos.: ☐ _____ mm	☐	☐	☐
			Microscopic	☐	☐	☐					☐	☐	☐
☐	☐	BLOOD LEAD LEVEL Date: ____ / ____ / ____	Level _____ ug/dl	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.									

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: _____			
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 _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ _____
_____ Dentist's Signature
_____ Date

PHYSICIAN'S SIGNATURE			
_____ Examiner's Signature	_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	MI _____ ZIP Code	(_____) _____ 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.

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.