

**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 _____ <b>OR</b> Date of Last Assessment _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other (please describe) _____	

<b>Reason for Medication</b>		
<b>Concussion History</b>		
<b>Parent/Guardian Signature</b>	<b>Date</b>	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials</b> _____

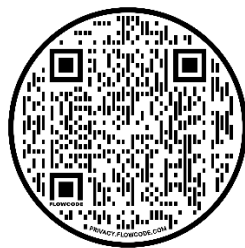
**SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS**

Required for Child Care and Head Start / Early Head Start

<b>Test and Measurements</b>						
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)	R/L	R/L	
			<input type="checkbox"/> OAE (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> Other (R= Right, L=Left)	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			
<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height			
			Weight			
		Other _____	Other _____			
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	➡			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading _____			

**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.

Complete pediatric tuberculosis risk assessment available at:  
[https://www.michigan.gov/documents/mdhhs/4\\_MI\\_Pediatric\\_TB\\_Risk\\_Assessment\\_661537\\_7.pdf](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.



## 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 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	
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		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.	3		
	2	4				
Rotavirus (RV1/RV5)	1	3	* <b>Note:</b> 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					
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		

Child's Name: \_\_\_\_\_

**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): <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 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.