



Early Childhood Center

Laura Tinsley, BPS Early Childhood Specialist 248.203.5800 Fax: 248.203.5804
LTinsley@birmingham.k12.mi.us 2121 Midvale Street Birmingham, MI 48009

Dear Parents,

Here are **important** instructions for completing your child's Health Appraisal form. Some areas are filled out by parents and others at the doctor's office. It is very important that you make sure this form is completed as seen below. These guidelines are requirements by the State of Michigan Department of Human Services and every little detail counts. It is important that we are in full compliance. We are required to have a Health Appraisal on file for each child and it must be completed **and signed** by the doctor. You can help us by doing the following: please double check the form **before** leaving the doctor's office. (Sections that the doctor needs to complete are in pink.) **Please note, incomplete forms will not be accepted and we will ask you to return to your doctor's office.**

Please confirm:

1. The doctor has signed and dated the form. (Please note, the doctor cannot be the child's parent.)
2. The doctor has checked the two boxes in Section 4.
3. The doctor has filled in the exam date (bottom right of first page.)
4. The immunization section is completed or attached as a separate document.
5. The physical exam section is fully completed.

There is also a parent section (highlighted in blue) that needs to be completely filled out. Please make sure you do the following before turning it in:

1. Fill in all requested Personal information.
2. Fill in Section 1 - Health History (answer questions on left and fill in information on right).
3. Sign and date at the end of Section 1.

HEALTH APPRAISAL

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 must be completed by the doctor and signed by the doctor. **PLEASE DO NOT SIGN YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.**

PERSONAL

Parents fill all of this section in and answer the questions by checking the correct box.

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

SECTION I - HEALTH HISTORY

Is your child having any of the problems listed below?	Birth History:
☐ 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?	

Parent sign and date here

Parent/Guardian Signature / / Date

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements	Examinations and/or Inspections
VISION	HEARING
HEARING	URINALYSIS
BLOOD/LEAD LEVEL	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	VACCINES (Circle Type)	DATE ADMINISTERED
Hepatitis B (Hep B)	1 3	Hepatitis A (Hep A)	1 2
DtaP/DTaP/DT/d	1 4	Influenza (TIV/LAN)	1 3
Tdap	1 3		
Haemophilus Influenzae type b (Hib)	1 3		
Polio (IPV/OPV)	1 3		
Pneumococcal Conjugate (PCV/PCV13)	1 3		
Rotavirus (RV1/RV5)	1 3		
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

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 child's school or local health department.

Parent/Guardian refused immunizations: ☐

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ child's name. 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 / / 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 Departments of Human Services, Education, Community Health, 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.