Health Appraisal

Examination Date _____

Child's Name – Last Name: First Name:	Date of Birth:	Gender ☐ Female ☐ Male
Home Address:	Home Phone No.:	Alternate Phone No.:
Parent/Guardian Name:	Allergies and/or Special Needs (List):	
Does your child have health insurance? ☐ Yes ☐ No	Health Insurance Carrier's Name and Member ID No.:	
I give my consent for my child's Health Care Provider and Head Start discuss the information on this form. ☐ Yes ☐ No		
Signature:	Date:	Medication(s):

SECTION II – IMMUNIZATIONS	**VACCINE TYPE**	**MO/DAY/YR**	**MO/DAY/YR**
Statement such as "UP-TO-DATE" or "COMPLETE" will not be accepted Admission to school may be denied on the basis of this information	***MMR Measles, Mump, Rubella***	1.	2.
VACCINE (Specify Type) **DATE ADMINISTERED** **MO/DAY/YR** **MO/DAY/YR**	**Varicella (Chicken Pox)**	1.	2.
	History of Chicken Pox Disease	☐ Yes ☐ No Date: _____	

Dta/DTP/TD	1.	6.	Hepatitis B (HBV)	1.	3.
	2.	7.		2.	4.
	3.	8.	Pneumococcal Conjugate PCV	1.	3.
	4.	9.		2.	4.
	5.	10.	Other Vaccinations (Specify)	1.	3.
Haemophillus influenza type b (HIB)	1.	3.	Note If Measles, Mumps, Rubella (MMR) & Chicken Pox vaccines were given before 12 months of age, the dosage must be repeated. Indicate physician's diagnosis or laboratory evidence of immunity as applicable		
	2.	4.			
POLIO – IPV – OPV	1.	4.			
	2.	5.	VACCINES WAIVED DUE TO REACTIONS/CONTRADICTIONS _____		
	3.	6.	RELIGIOUS OBJECTIONS _____		

Type of Screening	Date Performed	Record Number	Type of Screening	Date Performed		
Hgb/HCT			Hearing		Passed	Failed
Lead			Vision		Passed	Failed
Blood Pressure		/	TB/Chest X-Ray		Neg.	Pos.
Ht/Wt			Sickle Cell, If Positive		Trait	Disease

	Normal	Under Care	Referred		Normal	Under Care	Referred		Normal	Under Care	Referred
Eyes				Lungs				Skin			
Ear/Nose/Throat				Breast				Extremities			
Teeth				Abdomen				Spine			
Thyroid				Genitalia				General Nutrition			
Lymphatic System				Rectal				Speech			
Heart/Vascular System								Other			

Essential Findings Deviating from the Normal and/or Recommendations:

Examiner's Name in Print:	Telephone No:
Examiner's Signature:	Medical Follow-up Indicated
Office/Clinic Address: City: State: Zip:	☐ Yes ☐ No

.Developed in Cooperation with The Michigan Department of Community Health, Michigan Department of Day Care Licensing, Michigan State Medical Society