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.)

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)

MI       /  /

PARENT/GUARDIAN (Last, First, Middle)                  HOME TELEPHONE NUMBER

ADDRESS (Number & Street)        (City)        (ZIP Code)   WORK TELEPHONE NUMBER

MI     (  )

SECTION I - HEALTH HISTORY

# 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?     If yes, list medications:

Reason for Medication

☐   ☐   Was the health history reviewed by a health professional?

☐   ☐ Yes ☐ No Examiner’s Initials: __________

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

<table>
<thead>
<tr>
<th>No.</th>
<th>Test</th>
<th>Date:    /    /</th>
<th>Normal</th>
<th>Referred</th>
<th>Under Care</th>
<th>No.</th>
<th>Test</th>
<th>Date:    /    /</th>
<th>Normal</th>
<th>Referred</th>
<th>Under Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VISION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HEIGHT &amp; WEIGHT</td>
<td></td>
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<td></td>
<td>Visual Acuity</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Muscle Imbalance</td>
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<td>Other</td>
<td>Other</td>
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<td>Other</td>
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<tr>
<td></td>
<td>HEARING</td>
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<td></td>
<td>HEMOGLOBIN / HEMATOCRIT</td>
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<tr>
<td></td>
<td>Audiometer</td>
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<td>BLOOD PRESSURE</td>
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<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td>Type:</td>
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<tr>
<td></td>
<td>URINALYSIS</td>
<td></td>
<td></td>
<td>Sugar</td>
<td></td>
<td></td>
<td>TUBERCULIN</td>
<td></td>
<td></td>
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<td>Album</td>
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<td>Date:    /    /</td>
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<td>Microscopic</td>
<td></td>
<td></td>
<td>Neg.: □ Pos.: □ _______ mm</td>
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<td></td>
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<tr>
<td></td>
<td>BLOOD LEAD LEVEL</td>
<td></td>
<td>Level</td>
<td>ug/dl</td>
<td></td>
<td></td>
<td>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.</td>
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</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1 3</td>
</tr>
<tr>
<td>DTaP/DTP/DT/Td</td>
<td>1 4 2</td>
</tr>
<tr>
<td>Haemophilus Influenzae</td>
<td>1 3</td>
</tr>
<tr>
<td>Polio (IPV/OPV)</td>
<td>1 3</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>1 3</td>
</tr>
<tr>
<td>Rotavirus (RV1/RV5)</td>
<td>1 3</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1 2</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1 2</td>
</tr>
</tbody>
</table>

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)

- 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 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.