Developed in Cooperation With: Departments of Consumer and Industry Servi Community Health, and Education; Michigan State Medical Society; Michigan Association of Osteopathic Physicia	APPRAISAL	 □ School □ Children's Group □ Child Care Center □ Child Caring Institution □ Other: 				
Dear Parent or Guardian: The following information is requested so that the school an requested in Section I. Section II may be certified by transci doctor, nurse, and dentist. (BE SURE TO BRING YOU CH	ription of information from the	ne certificate of immunization.	The remaining section	ds of the child. Fill ns (III, IV, V) are to	out the information be completed by a	
PERSONAL						
Child's Name Last	First	Sex	Date of Birth	1		
Last	FIISt	Middle				
AddressNumber & Street		City Zip		e		
		2.19				
Parent's or Guardian's NameLast	First	Middle		Home)		
Addraga			Talanhana //	Work)		
AddressNumber & Street		City Zip		vv01K)		
SECTION I — HEALTH HISTORY		SECTION II - IMN	NUNIZATION			
s your child having any of the problems listed below?	YES NO	Statements such as "UP T Admission to school may I				
Allergies or reactions: (For example, food,						
medication, or other)		VACCINE: DTP/DT/Td TYPE	Mo./Day/Yr:	ADMINISTER	RED Mo./Day/Yr:	
2. Hay fever, asthma, or wheezing		DTaP (Specify Type)	1. WIO./Day/11.	6.	vio./Day/ f1.	
3. Eczema or frequent skin rashes		(Opeciny Type)	2.	7.		
4. Convulsion/Seizures			3.	8.		
Heart trouble Diabetes			4.	9.		
7. Frequent colds, sore throats, earaches			5.	10.		
(4 or more per year)		Haemophilus influenzae type b	1.	3.		
Trouble with passing urine or bowel movements			2.	4.		
9. Shortness of breath		POLIO (Specify Type)	1.	4.	THE STATE OF THE PROPERTY OF T	
0. Speech problems		OPV/IPV	2.	5.		
Menstrual problems			3.	J		
Dental problems. Date of last examination		Note: If Measles, Rubella,	or Mumps vaccines wer	e given before 12 mo	onths of age,	
13. Other		the dosage must be repea	Mo./Day/Yr:		Mo./Day/Yr:	
		Varicella	1.	2.		
Please explain any problem areas identified above:			1.			
		Hepatitis B	2.			
			1.	3.		
		OTHER VACCINES	2.			
		Indicate physician diagnosis of disease or laboratory evidence of immunity as applicable				
Ooes your child take any medication regularly?	□ YES □ NO	VACCINES WAIVED DUE REACTIONS/CONTRAINI RELIGIOUS OBJECTIONS	DICATIONS/			
yes, what medication?		I certify that the i	mmunization dates are t	rue to the best of my	knowledge	
					anautono	
Reason for medication:	A PARTY TO THE OWN AND A SECOND SECON	Validatina Ciatura		Tial -		
		Validating Signature		Title	Date	

Parent's Signature:_

^{*}According to Act 368, Public Acts 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 waiver forms are properly prepared, signed, and delivered to school administrators. Forms for these exemptions are available at your school or local health department.

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM	NORMAL	AND/OF	RECOMM	MENDATIONS			
	all to be a second of the seco						
A CONTRACTOR OF THE CONTRACTOR		TEST	S AND ME	ASUREMENTS			
	Normal	Under Care	Referred		Normal	Under Care	Referred
Vision Tested?				Urinalysis Done? Sugar Yes No Albumin Date Microscopic			
Hearing Tested? Audiometer Yes No Other Date				Blood Pressure Measured? Yes No Reading			
Hemoglobin/Hemotocrit Tested? Yes No				Height Weight Other:	-		
ESSENTIAL FINDINGS DEVIATING FROM	INORMAL	AND/OF	R RECOMM	MENDATIONS			
SECTION IV - RECOMMENDATIONS Is there any defect of vision, hearing, or other If yes, please explain	condition	for which	the schoo	I could help by seating or other action?	Yes	No	
Should the student's activity be restricted bed Classroom Playground Gymnasium				Ilness? Yes No If yes, check below and nepetitive Sports Camp Other	d explain deg	gree of res	triction:
Examiner's Signature Number & Street City)ate	Zip	Exa	miner's Name (print or type) Telephone	Degree	or Licen	se
SECTION V - DENTAL EXAMINATION		And an experience to the second secon					
I have examinedtee Child's Name	th and mak	e the fol	lowing reco	mmendations as to treatment:			
COMMENTS:			•	Dentist's Signature		Date	
							article - recorded biffer Florid Salauri (men) Salauri (me