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 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)
Leo Yiming Dong				07 / 23 / 2018
ADDRESS (Number & Street)	(City)		(ZIP Code)	TODAY'S DATE (mm/dd/yy)
1388 Hathaway Rising	Rochester Hills	MI	48306	05 / 10 / 2022
PARENT/GUARDIAN (Last, First, Middle)				HOME TELEPHONE NUMBER
Maopeng Dong				(248) 229 9624
ADDRESS (Number & Street)	(City)		(ZIP Code)	WORK TELEPHONE NUMBER
1388 Hathaway Rising	Rochester Hills	MI		(248) 229 9624

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# 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?

Reason for Medication

Parent/Guardian Signature Maopeng Dong Date 05/10/2022

Birth History: C section

Are there any current or past diagnosis(es) ☐ Yes ☒ No

If yes, please describe:

If yes, list medications:

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

No	Yes	Was child tested for:	Test results:		Normal	Referred	Under Care
☐	☒	VISION Date: 07 / 24 / 2018	Normal	Visual Acuity	X		
			Normal	Muscle Imbalance	X		
			Other:				
☐	☒	HEARING Date: 07 / 24 / 2018	Normal	Audiometer	X		
			Other:				
☐	☒	URINALYSIS Date: 07 / 24 / 2018	Normal	Sugar	X		
			Normal	Albumin	X		
			Normal	Microscopic	X		
☐	☒	BLOOD LEAD LEVEL Date: 07 / 24 / 2018	Level _____ ug/dl				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☒	HEIGHT & WEIGHT	Height	X		
			Weight	X		
☐	☐	Other: _____	Other			
☐	☒	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☒	BLOOD PRESSURE	Reading: _____			
☐	☒	TUBERCULIN Date: 07 / 24 / 2018	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

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.

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 MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: 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.

Parent/Guardian refused immunizations: ☐

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)

No	Yes	
☒	☐	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 name)'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.

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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.