# MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

**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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

**(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).**

## SECTION 1 – 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) |
| Parent/Guardian (Last, First, Middle) | Home/Cell Phone Number |
| Address (Number, Street, City, Zip Code) | Work Phone Number |

## SECTION 2 – HEALTH HISTORY

| Yes | No | Resolved | Is your child having any of the problems listed below? | Birth History |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 1. Allergies or Reactions (for example, food, medication or other) | |
| ☐ | ☐ | ☐ | 2. Anaphylaxis | |
| ☐ | ☐ | ☐ | 3. Does your child take any medication(s) regularly? | If yes, list medications |
| ☐ | ☐ | ☐ | 4. Hay Fever, Asthma, or Wheezing | |
| ☐ | ☐ | ☐ | 5. Eczema or Frequent Skin Rashes | |
| ☐ | ☐ | ☐ | 6. Convulsions/Seizures | |
| ☐ | ☐ | ☐ | 7. Heart Trouble | |
| ☐ | ☐ | ☐ | 8. Diabetes | |
| ☐ | ☐ | ☐ | 9. Frequent Colds, Sore Throats, Earaches (4 or more per year) | Are there any current or past diagnosis(es) ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | 10. Trouble with Passing Urine or Bowel Movements | If yes, describe |

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 11. Shortness of Breath | |
| ☐ | ☐ | ☐ | 12. Speech Problems | |
| ☐ | ☐ | ☐ | 13. Menstrual Problems | |
| ☐ | ☐ | ☐ | 14. Dental Problems<br>Date of Last Exam OR<br>Date of Last Assessment | |
| ☐ | ☐ | ☐ | 15. Other (describe) | |

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

**SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS**

Required for Child Care and Head Start / Early Head Start

**Test and Measurements**

| Yes | No | Was child test for | Tests and results | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Vision | Visual Acuity | ☐ | ☐ | ☐ |
| | | Date | Muscle Imbalance | ☐ | ☐ | ☐ |
| | | | Other | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hearing | ☐ Audiometer (R= Right, L=Left) | | | |
| | | Date | ☐ OAE (R= Right, L=Left) | | | |
| | | | ☐ Other (R= Right, L=Left) | | | |
| ☐ | ☐ | Urinalysis | Sugar | ☐ | ☐ | ☐ |
| | | | Albumin | ☐ | ☐ | ☐ |
| | | | Microscopic | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Lead Level | Level ug/dl | ☐ | ☐ | ☐ |
| | | Date | | | | |

**Note:** All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Height & Weight | Height | ☐ | ☐ | ☐ |
| | | | Weight | ☐ | ☐ | ☐ |
| ☐ | ☐ | Other | Other | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hemoglobin/Hematocrit | ⇨ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Pressure | Reading | ☐ | ☐ | ☐ |

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

**Examinations and/or Inspections**

Essential Findings Deviating from Normal — Exam Date

## SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

| Vaccines (Select Type) | Date Administered (mm/dd/yy) | | |
|---|---|---|---|
| Hepatitis B (HepB) | 1. | 2. | 3. |
| | 4. | | |
| DTaP/DTP/DT/Td | 1. | 2. | 3. |
| | 4. | 5. | 6. |
| Tdap | 1. | | |
| *Haemophilus Influenzae* type b (HIB) | 1. | 2. | 3. |
| | 4. | | |
| Polio (IPV/OPV) | 1. | 2. | 3. |
| | 4. | 5. | |
| Pneumococcal Conjugate (PCV) | 1. | 2. | 3. |
| | 4. | | |
| Rotavirus (RV1/RV5) | 1. | 2. | 3. |
| Measles, Mumps, Rubella (MMR/MMRV) | 1. | 2. | 3. |
| Varicella (Chickenpox), (Var, MMRV) | 1. | 2. | |
| Hepatitis A (HepA) | 1. | 2. | 3. |

| | | | |
|---|---|---|---|
| Influenza (IIV/LAIV) | 1. | 2. | 3. |
| | 4. | | |
| Meningococcal (MCV4, MenABCWY ) | 1. | 2. | 3. |
| Meningococcal B (Bexsero, Trumenba, MenABCWY) | 1. | 2. | 3. |
| Human Papillomavirus (HPV) | 1. | 2. | 3. |

Additional 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.

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

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

**SECTION 5 - 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?
☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?
☐ Yes ☐ No

Check all that apply
☐ Classroom ☐ Playground ☐ Gymnasium
☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

## SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature

Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

## SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print)

Degree or License

Telephone Number

Examiner's Signature

Date

Address

City

State Zip Code
MI

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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 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.