

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) / / |
| ADDRESS (Number & Street) | (City) | (ZIP Code) | TODAY'S DATE (mm/dd/yy) / / |
| PARENT/GUARDIAN (Last, First, Middle) | | | HOME TELEPHONE NUMBER () |
| ADDRESS (Number & Street) | (City) | (ZIP Code) | WORK TELEPHONE NUMBER () |

SECTION I - HEALTH HISTORY

| Yes | No | Resolved | # Is your child having any of the problems listed below? | |
|--------------------------|--------------------------|--------------------------|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1 Allergies or Reactions (for example, food, medication or other) | Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2 Hay Fever, Asthma, or Wheezing | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3 Eczema or Frequent Skin Rashes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4 Convulsions/Seizures | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5 Heart Trouble | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6 Diabetes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7 Frequent Colds, Sore Throats, Earaches (4 or more per year) | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8 Trouble with Passing Urine or Bowel Movements | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9 Shortness of Breath | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 Speech Problems | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11 Menstrual Problems | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12 Dental Problems: Date of Last Exam / / | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (please describe): _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication(s) regularly? | |
| | | | Reason for Medication | |
| | | | _____ / / | |
| | | | Parent/Guardian Signature _____ Date _____ | |

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 | No | Yes | Was child tested for: | Test results: | Normal | Referred | Under Care |
|--------------------------|--------------------------|-------------------------------|---|--------|----------|------------|--|--------------------------|---|---|--------|----------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | VISION Date: / / | Visual Acuity Muscle Imbalance Other: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> | HEIGHT & WEIGHT Other: _____ | Height Weight Other: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING Date: / / | Audiometer Other: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> | HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE | Reading: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | URINALYSIS Date: / / | Sugar Albumin Microscopic | | | | <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULIN Date: / / | Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD LEAD LEVEL Date: / / | Level _____ ug/dl | | | | 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: / / |

