

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.)**

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

Resolved			# Is your child having any of the problems listed below?		Birth History:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)			
<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)		Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements		If yes, please describe:	
<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"/>		Does your child take any medication(s) regularly?		If yes, list medications:	
Reason for Medication				⇒		
_____ Parent/Guardian Signature			_____/_____/_____ Date		Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____	

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	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
		Date: ____/____/____	Other:				<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT				
			Other:				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
		Date: ____/____/____											
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
			Albumin										
		Date: ____/____/____	Microscopic						Date: ____/____/____	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	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.						
		Date: ____/____/____											

Essential Findings Deviating from Normal:		Exam Date: / /