# 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: ____/____/____

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Today's Date: ____/____/____

Parent/ Guardian: _____ (Last) _____ (First) _____ (Middle) Telephone: (____) _____ (Home)

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Telephone: (____) _____ (Work)

## 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): _____ |

Birth History:

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

If yes, please describe

☐ ☐ Does your child take any medication(s) regularly?

Reason for medication:

If yes, list medications:

_____ (Parent/Guardian Signature) ____/____/____ (Date)

Was the health history reviewed by a health professional?

☐ Yes ☐ No *Examiner's Initials:* _____