

McLaren Print System Order

Order No: 51973 Reprint Previous Order No: 5602
Order Date: 2020-01-27
User: Joseph Daiuto
Phone: 810-496-2500

Ship Location: Fenton CMC-Attn Joe DAiuto
2420 Owen Road
Fenton, MI 48430

Forms
Quantity: 500
Paragon Dept No: 50013
Dept Name: Fenton CMC
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34521
Item Description: Health Appraisal (State of Michigan)
Revision Date: 7/2015
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Medical Group
HEALTH APPRAISAL

Star Patient or Suspect: 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 II may be verified by the transmission of information from the health care professional. The remaining sections describe complementary subjects, none and details. **BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE COORDINATOR.**

PERSONAL

Parent's Name (Last, First, Middle)	Child's Birth Date	Child's Birth Sex	Child's Birth Weight
Parent's Address (Street, City, State, Zip)	Parent's Phone Number	Parent's Email Address	Parent's Occupation
Child's Name (Last, First, Middle)	Child's Birth Date	Child's Birth Sex	Child's Birth Weight

SECTION I - HEALTH HISTORY

I. A. In your child's history, any of the problems listed below?

<input type="checkbox"/> Allergies or Reactions (for example, food, medication or other)	Block Medicine
<input type="checkbox"/> Any form of Asthma or Wheezing	
<input type="checkbox"/> Epilepsy or Seizures (Grand Mal, Petit Mal)	
<input type="checkbox"/> Diabetes/Mellitus	
<input type="checkbox"/> Heart Trouble	
<input type="checkbox"/> Stomach	
<input type="checkbox"/> Frequent Colds, Sore Throats, Earaches or in nose per year	
<input type="checkbox"/> Trouble with Peeing (Leaky or Blood in Urine)	
<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Speech Problems	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Dental Problems, Date of Last Exam	
<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Does your child take any medications regularly?	

II. A. Has the health history reviewed by a health professional? Yes No Not Sure

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS
Required for Under Sixes and Heart Start 1 Early Head Start

Tests and Measurements

Area	Test	Result	Area	Test	Result
Vital Signs	Temp		Vision	Distance	
	Heart Rate			Near	
	Respiration			Color	
	Blood Pressure			Visual Acuity	
Growth	Weight		Hearing	Frequency	
	Height			Intensity	
	Head Circumference			Location	
	Body Mass Index (BMI)			Other	

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