

McLaren Print System Order

Order No: 62467 Reprint Previous Order No: 5602
Order Date: 2021-05-18
User: Michele Lubick
Phone: 586-263-0320

Ship Location: McLaren Macomb Family Medicine-Michele
16700 21 Mile Rd., Suite 101
Macomb, MI 48044

Forms

Quantity: 100
Paragon Dept No: 71600
Dept Name: McLaren Macomb Family Medicine
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 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 II may be verified by the transmission of information from the health care professional. The remaining sections are to be completed by you, parent or guardian. **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"/> Convulsions		
<input type="checkbox"/> Heart Trouble		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Frequent Colds, Sore Throats, Earaches or other ear pain		Are there any current or past sleep apneas? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.
<input type="checkbox"/> Trouble with Feeding (Lumps or Blood in Stools)		
<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"/> / <input type="checkbox"/> / <input type="checkbox"/>		
<input type="checkbox"/> Other (please describe)		
<input type="checkbox"/> Does your child take any medications regularly? Please list medication		If yes, list medication
Parent/Guardian Signature <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/>	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Examiner's Initials	

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

Tests and Measurements

Area	Test/Measurement	Result	Area	Test/Measurement	Result
Vital Signs	Temperature		Vision	Visual Acuity	
	Heart Rate			Color Vision	
Eyes	Visual Acuity		Hearing	Hearing	
	Color Vision			Balance	
Ears	Hearing		Speech	Speech	
	Balance			Language	
Nose	Speech		Motor Function	Motor Function	
	Language			Fine Motor	
Throat	Motor Function		Social Interaction	Social Interaction	
	Fine Motor			Self-Care	
Chest	Social Interaction		Self-Care	Self-Care	
	Self-Care				

Examiner's Signature (Required for Heart Start 1)

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