

**McLaren Print System Order**

Order No: 7476  
 Order Date: 2014-12-03  
 User: Susan Mullins  
 Phone: 586-226-2032

Ship Location: McLaren Macomb Pediatrics  
 16700 21 Mile Rd Ste 104  
 Macomb , MI 48044

Forms  
 Quantity: 500  
 Paragon Dept No: 72550  
 Dept Name: McLaren Macomb Pediatrics  
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-34521  
 Item Description: Health Appraisal (State of Michigan)  
 Revision Date: 2/2011  
 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

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, emotional and educational needs of the child. Fill out the information requested in Section I. Section II may be completed by the completion of information from the certificate of immunization. The remaining portions are to be completed by a doctor, nurse or social worker. **BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.**

**PERSONAL**

CHILD'S FULL NAME	DATE OF BIRTH (MM/DD/YY)
CHILD'S BIRTH DATE	DATE OF BIRTH (MM/DD/YY)
CHILD'S BIRTH PLACE	DATE OF BIRTH (MM/DD/YY)
CHILD'S BIRTH DATE	DATE OF BIRTH (MM/DD/YY)
CHILD'S BIRTH PLACE	DATE OF BIRTH (MM/DD/YY)

**SECTION I: HEALTH HISTORY**

**I.1. Has your child had any of the following health issues?**

<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	<b>Birth History</b>
<input type="checkbox"/> Allergies to foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	
<input type="checkbox"/> Allergies to medicines, foods, animals, insects, radiation, or other	

**I.2. Has your child had any medical or surgical history?**

**I.3. Has your child had any medical or surgical history?**

**SECTION II: PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS**  
 Prepared for Child Care and Head Start / Early Head Start

**Tests and Measurements**

<input type="checkbox"/> Weight	<input type="checkbox"/> Height	<input type="checkbox"/> Head Circumference	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Heart Rate	<input type="checkbox"/> Lung Sounds	<input type="checkbox"/> Abdominal	<input type="checkbox"/> Genital
<input type="checkbox"/> Skin	<input type="checkbox"/> Mouth	<input type="checkbox"/> Throat	<input type="checkbox"/> Neck	<input type="checkbox"/> Back
<input type="checkbox"/> Limbs	<input type="checkbox"/> Reflexes	<input type="checkbox"/> Coordination	<input type="checkbox"/> Balance	<input type="checkbox"/> Gait

**HEALTH APPRAISAL**

Parent Name: \_\_\_\_\_  
 Date of Exam: \_\_\_\_\_