

SECTION III – IMMUNIZATIONS					
Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*					
VACCINES	DATE ADMINISTERED MM/DD/YYYY		DATE ADMINISTERED MM/DD/YYYY		
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2				
DTaP/DTP/DT/Td/Tdap (Circle Type)	1	5	Influenza TIV/LAIV	1	3
	2	6		2	4
	3	7	Meningococcal MCV4 / MPSV4	1	2
	4	8	Human Papillomavirus (HPV)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	4
	2	4			
Polio – IPV / OPV (circle type)	1	3	OTHER Vaccines: Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Pneumococcal Conjugate (PCV7)	1	3		2	
	2	4	3		
Rotavirus (Rota)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2		*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.		
Measles, Mumps, Reubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge:					
_____				_____	
Health Professional's Signature				Title	
				Date	

		SECTION IV – RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)
No	Yes	is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other:

Other Recommendations:		

SECTION V – DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ child's name

Dentist's Signature
Date

PHYSICIAN'S SIGNATURE			
_____	Date	Examiner's Name (print or type)	Degree or License
Examiner's Signature			
Number & Street	City	MI	ZIP Code () Telephone:

Information required for:

Early On® - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing – Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Departments of Human Services, Education, Community Health; Michigan American Association of Pediatrics; Early Childhood Investment Corporation; Child Care Licensing, Head Start, Michigan State Medical Society; Michigan Association of Osteopathic Physicians and Surgeons