

STUDENT RECORD INFORMATION

Name of Child _____
(Last) (First) (Middle)

Name of Father _____

Name of Mother _____ Maiden Name _____

Education of Father: High School _____ College _____

Education of Mother: High School _____ College _____

Emergency Phone Number (Other than home) _____

Date of Child's birth _____ Sex _____
(Month) (Day) (Year)

Place of birth _____
(City) (State) (Country)

Race _____
(African American / Asian / Hispanic / American Indian / White / Multi-Race / Hawaiian
– Pacific Islander / Unknown)

Ethnicity _____ Non Hispanic/Latino _____ Hispanic/Latino

Number of children in family _____; Older _____; Younger _____

Occupation of Father _____

Occupation of Mother _____

Home Address _____
(Street) (City) (Township)

Home Phone Number _____ Cell Phone Number _____

E-Mail Address _____

Church Affiliation _____
(Name of Church) (Denomination)

The above information is needed for your child's permanent school record;
please fill in as completely as possible. Thank you.

PLEASE RETURN THIS FORM TO SCHOOL
BY AUGUST 15.

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 (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code)	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			Parent/Guardian Signature _____ Date _____	

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

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 (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	4
	2	5		2	4
	3	6			
Tdap	1		Meningococcal (MCV4 / MPSV4)	1	2
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	4		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
				2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
Rotavirus (RV1/RV5)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Measles, Mumps, Rubella (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					
_____			_____		____/____/____
<i>Health Professional's Signature</i>			Title		Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	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

_____ / _____ / _____
Date

_____ / _____ / _____
Date

PHYSICIAN'S SIGNATURE

_____ / _____ / _____
Date

_____ Degree or License

_____ MI _____ Telephone _____

_____ City _____ ZIP Code _____

_____ Number & Street

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 well-child care visit 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 Department of Health and Human Services, Education, 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.

Table 1

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs	
Hepatitis B (HepB)	1 st dose	2 nd dose			←----- 3 rd dose -----→													
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1 st dose	2 nd dose	3 rd dose				←----- 4 th dose -----→			5 th dose						
Haemophilus influenzae type b (Hib)			1 st dose	2 nd dose	See Notes		←----- 3 rd or 4 th dose, See Notes -----→											
Pneumococcal conjugate (PCV13)			1 st dose	2 nd dose	3 rd dose				←----- 4 th dose -----→									
Inactivated poliovirus (IPV <18 yrs)			1 st dose	2 nd dose	←----- 3 rd dose -----→							4 th dose						
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only					
or														or				
Influenza (LAIV)														Annual vaccination 1 or 2 doses	Annual vaccination 1 dose only			
Measles, mumps, rubella (MMR)					See Notes				←----- 1 st dose -----→			2 nd dose						
Varicella (VAR)									←----- 1 st dose -----→			2 nd dose						
Hepatitis A (HepA)					See Notes	2-dose series, See Notes												
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)																		Tdap
Human papillomavirus (HPV)														*	See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos)			See Notes											1 st dose		2 nd dose		
Meningococcal B																		See Notes
Pneumococcal polysaccharide (PPSV23)																		See Notes

Range of recommended ages for all children
Range of recommended ages for catch-up immunization
Range of recommended ages for certain high-risk groups
Recommended based on shared clinical decision-making or *see below in this page
No recommendation/ not applicable



Hearing & Vision Screenings



Children 3, 4 and 5 years of age.

Hearing and vision screenings are required prior to kindergarten and Head Start entrance, by the Michigan Public Health Code.

Schools require proof of the hearing and vision test. The health department offers the required hearing and vision screenings at no charge.

www.miOttawa.org/hearingvision

APPOINTMENTS ARE REQUIRED

Grand Haven.....(616) 846-8360

Holland.....(616) 396-5266

Hudsonville.....(616) 669-0040



12251 James Street • Holland, MI 49424-9661 • (616) 396-5266 • Fax (616) 393-5659
Branch Offices in Grand Haven & Hudsonville • www.miOttawa.org/miHealth
Revised 12/29/2014 by KWiegelmink



Proof of Hearing and Vision Screening

This form indicates that this child has had their hearing and vision screened by an authorized technician, physician or by the Ottawa County Health Department.

Name _____

Address _____

Date of Birth _____

DO NOT WRITE BELOW THIS LINE

.....

Vision

Hearing

Date Tested _____

Date Tested _____

- Passed vision screening
- Did NOT pass vision screening

- Passed hearing screening
- Did NOT pass hearing screening

Signature of authorized technician, physician or OCHD.

Hearing and vision screen is required to enter Young 5s and Kindergarten.

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

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HEADS UP

TO LEARN MORE GO TO >> [WWW.CDC.GOV/CONCUSSION](https://www.cdc.gov/concussion)

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