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

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ Yes ☐ No ***Examiner's Initials:*** _____

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
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

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	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*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.

Parent/Guardian refused immunizations: ☐

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:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ 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

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (___) _____

Number & Street City 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 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.

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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.

Wayne County GSRP Income Verification Form

These materials were developed under a grant awarded by the Michigan Department of Education

Program Name: _____ Child's Name: _____

	Income Source	Frequency* **W, BW, M, 2xM**	Amount Received
☐	Income Tax Form 1040		
☐	W-2		
☐	TANF Documentation (Cash Assistance only)		
☐	Pay Stub ***Use GROSS earnings, including overtime pay***		
☐	Unemployment		
☐	Written statement from employer		
☐	Foster Care Reimbursement		
☐	SSI Documentation		
☐	Child Support		
☐	Alimony		
☐	Pension(s)		
☐	Other:		
☐	No Income (see below)		
***W=weekly, BW=bi-weekly, 2xM=2 times per month, M=monthly**		**TOTAL:**	

Number Supported____ %FPL____ Quintile____ | Child is income-eligible for: Head Start (Q1-2)____ GSRP (Q3-5)____

Documentation of No Income *(complete only if parent has no income).*

☐ I am a student

☐ I affirm that I do not receive income from any source

☐ I am supported by family members

☐ Other: _____

Parent/Guardian's Name: _____ **Date:** _____

Parent/Guardian's Signature: _____

☐ GSRP Enrollment Specialist has reviewed income documentation, and

☐ GSRP Enrollment Specialist has attached copies of the income documentation

Staff Name: _____ Date: _____

Staff Signature: _____

Rev. January 2020 RH

Wayne County GSRP Intake Application

These materials were developed under a grant awarded by the Michigan Department of Education

****This form must be completed ONSITE with the enrollment specialist and parent/guardian****

Date of Application: _____ **Child's Name:** _____

Child's Birthdate: _____ **Place of Birth:** _____ **Gender:** _____

Proof of Birth*: _____ *If applicable,* Date of Arrival in the United States: _____
*Refer to Eligibility Factor Guidance Sheet for types of documents that can be accepted.

Child's Address: _____ City: _____ Zip Code: _____

Parent/Guardian's Name:_____

Address (*if not child's address*):_____ City: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Parent/Guardian's Name:_____

Address (*if not child's address*):_____ City: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Has your child attended school anywhere before? _____ If yes, date they started school: _____

Name of School: _____ City, State: _____

List ALL household members for which you are financially responsible (include self, other adults, and children).

Name	Relationship to Child	Age

EF-1 Family Income (Estimated annual income (last 12 mos.) before deductions, including overtime): $_____
*(**MUST** include income of all family members financially responsible for support of child: 1040, W2, most recent pay stubs, unemployment, child support, alimony, DHS, SSI)*

EF-1 Does your family receive benefits from Department of Human Services (DHS), SSI? _____

If YES, please explain: _____

Parent/Guardian's Employment Status: Unemployed_____ Part Time_____ Full Time_____ Seasonal_____

Job Description: _____

Parent/Guardian's Employment Status: Unemployed_____ Part Time_____ Full Time_____ Seasonal_____

Job Description: _____

EF-2 Has your child been diagnosed with a disability or developmental delay? _____

If YES, please explain: _____
Parents MUST provide the most current IEP to the GSRP office during the application process.

EF-3 Has your child been expelled from preschool or a childcare center? _____

EF-4 Primary language spoken in the home: _____ Is the student's ethnicity Hispanic or Latino? _____

Which of the following is the student's race (if multi-racial, place a check mark for each that applies):

American Indian or Alaska Native_____ Black or African-American_____ White_____

Asian American_____ Native Hawaiian or other Pacific Islander_____ Hispanic or Latino_____

EF-5 Highest grade or degree completed: Parent/Guardian: _____ Parent/Guardian_____

EF-6 Has someone in your home ever been a victim of abuse and/or neglect? _____

EF-7 Who has legal custody of the child? Mother_____ Father_____ Foster Care_____ Legal Guardian_____ Grandparent_____

If guardian or foster parent (other than biological parent), please complete:

Legal Guardian's Name(s): _____ **Case Number:** _____

EF-7 Is there any other information you believe would qualify your child for our program?**

Please explain: _____
**Refer to Eligibility Factor Guidance Sheet for other qualifications.

How did you hear of the Great Start Readiness Program? _____

By signing this application, you certify that the information given is true and accurate to the best of your knowledge.

Parent/Guardian's Name (please print): _____

Parent/Guardian's Signature: _____ **Date:** _____

By signing this intake application, I certify that I completed this form with the parent/guardian and the information is correct to the best of my knowledge.

Staff Name (please print): _____

Staff Signature: _____ **Date:** _____