# Child Information Record

Information on this form is REQUIRED by Michigan State Law

EVERY LINE MUST BE COMPLETED BEFORE YOUR CHILD WILL BE ALLOWED TO ATTEND CLASS

Name of child (Last, First, M.I.) Nickname Birthdate Home Phone

Address City State

Parent Name Address (if not the child's) Phone

Employer Position Employer Address

Employer Phone Hours of Employment Email Address

Cell Phone Pager

Parent Name Address (if not the child's) Phone

Employer Position Employer Address

Employer Phone Hours of Employment Email Address

Cell Phone Pager

AUTHORIZATION: Name(s) of Person(s) and Phone Number TO WHOM CHILD MAY BE RELEASED (and relationship to child)

EMERGENCY CONTACT: (Local person to be notified in an emergency when Parent cannot be reached)
Name Phone (home/work/cell) Address Relationship to child

Name of Child's Physician or Health Clinic Address Phone

Hospital Preferred for Emergency Treatment Health Insurance Policy Name Health Insurance Number

Allergies, if any Date of last Tetanus Shot

Any conditions your child has which may require special assistance, or anything you would like to share with us to better serve your child?

Name of Child's Dentist Address Phone

MEDICAL TREATMENT – Please check one of the boxes:

❐ I give my permission to Summer Kampers to secure emergency medidcal and/or emergency surgical treatment fo the above named minor child while in care.

❐ I do not give permission to Summer Kampers to secure emergency medical and or emergency surgical treatment for the above named child while in care.

Upon signing this agreement, the parent, legal guardian or responsible adult verifies that the child listed above is current on all immunizations, in good health, and may participate in all program activities.

Signature of Parent or Guardian: Date:

Developed in Cooperation With:

Department of Human Services,
Departments of Community Health, and Education;

Michigan State Medical Society;

Michigan Association of Osteopathic Physicians and Surgeons

# HEALTH APPRAISAL

☐ School
☐ Children's Group
☐ Child Care Center
☐ Child Caring Institution
☐ Other: ____________

Dear Parent or Guardian: The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section I. Section II may be certified by transcription of information from the certificate of immunization. The remaining sections (111, IV, V) 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 ______________________ Sex ______ Date of Birth ____________
Last First Middle

Address ______________________ Today's Date ____________
Number & Street City Zip

Parent's or Guardian's Name ______________________ Telephone (Home) ____________
Last First Middle

Address ______________________ Telephone (Work) ____________
Number & Street City Zip

## SECTION I -- HEALTH HISTORY

| Is your child having any of the problems listed below? | Yes | No |
|---|---|---|
| 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 examination: | | |
| 13. Other | | |
| | | |
| | | |

Please explain any problem areas identified above:

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, what medication? ____________

Reason for Medication: ____________

Parent's Signature: ____________

## SECTION II --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. *

| VACCINE | Type | DATE ADMINISTERED Mo/Day/Yr. | Type | Mo/Day/Yr. |
|---|---|---|---|---|
| DTaP/DTP/Td (Specify Type) | | 1. | | 6. |
| | | 2. | | 7. |
| | | 3. | | 8. |
| | | 4. | | 9. |
| | | 5. | | 10. |
| Haemophilus influenzae type b (HIB) | | 1. | | 3. |
| | | 2. | | 4. |
| POLIO IPV/OPV (Specify Type) | | 1. | | 4. |
| | | 2. | | 5. |
| | | 3. | | |
| Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated. | | | | |
| MMR | | 1. | | 2. |
| Varicella (Chickenpox) | | 1. | | 2. |
| Chickenpox History of Disease | | ☐ Yes ☐ No | | Date: |
| Hepatitis B HBV | | 1. | | 3. |
| | | 2. | | |
| Pneumococcal Conjugate (PCV) | | 1. | | 3. |
| | | 2. | | 4. |
| Other Vaccines | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Indicate physician diagnosis or laboratory evidence of immunity as applicable | | | | |
| VACCINES WAIVED DUE TO REACTIONS/CONTRAINDICATIONS/ RELIGIOUS OBJECTIONS | | | | |

I certify that the immunization dates are true to the best of my knowledge

Validating Signature Title Date

*According to Act 368, Public Acts 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 waiver forms are properly prepared, signed, and delivered to school administrators. Forms for these exemptions are available at your school or local health department.

## SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

### EXAMINATIONS AND/OR INSPECTIONS

| ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS |
|---|
| |
| |
| |

### TESTS AND MEASUREMENTS

| | Normal | Under Care | Referred | | Normal | Under Care | Referred |
|---|---|---|---|---|---|---|---|
| Vision Tested? ☐ Yes ☐ No Date_______________ ☐ Visual Activity ☐ Ocular Muscle ☐ Other_______ | | | | Urinalysis Done? ☐ Yes ☐ No Date______________ ☐ Sugar ☐ Albumin ☐ Microscopic | | | |
| Hearing Tested? ☐ Yes ☐ No Date___________________ ☐ Audiometer ☐ Other_________ | | | | Blood Pressure Measured? ☐ Yes ☐ No Reading__________________ | | | |
| Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No | | | | Height_____________ Weight_________ Other: | | | |
| Blood Lead Level Tested? ☐ Yes ☐ No Date______________ Reading__________ | | | | Blood Lead level recommended for all children age six and under | | | |

| ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS |
|---|
| |

Tuberculin Test (if given) Date _______________ Type____________ ☐ Negative ☐ Positive ___________________ mm.

## SECTION IV -- RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action? ☐ Yes ☐ No

If yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? ☐ Yes ☐ No If yes, check below and explain degree of restriction:

☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Camp ☐ Other

| Examiner's Signature | Date | Examiner's Name (print or type) | Degree or License |
|---|---|---|---|
| Number & Street | City | Zip | Telephone |

## SECTION V -- DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ______________________ teeth and make the following recommendations as for treatment:

Child's Name

Dentist's Signature Date

## COMMENTS

| |
|---|
| |
| |