



1250 Kensington Rd, Bloomfield Hills, MI 48304-3029

**2010-2011 Student Health Appraisal**

<b>STUDENT NAME:</b>	LAST	FIRST	SEX	GRADE	DATE OF BIRTH	AGE
<b>STUDENT ADDRESS:</b>	STREET		CITY		ZIP	
	FATHER'S / GUARDIAN'S NAME		WORK PHONE	MOTHER'S / GUARDIAN'S NAME		WORK PHONE
	CELL PHONE			CELL PHONE		

**MEDICAL HISTORY**

	YES	NO		YES	NO
<b>Has your child ever had:</b>			<b>Does your child now have:</b>		
Fainting			Painful Joints		
Diphtheria			Backaches		
Scarlet Fever			Pounding of Heart		
Rheumatism			Shortness of Breath		
Rupture			Frequent Urination		
Rheumatic Fever			Cough		
Poliomyelitis			Nosebleeds		
Pneumonia			Frequent Sore Throats		
Asthma			Stomach Pains		
Diabetes			Blurred Vision		
Heart Disease			Headaches		
Kidney Disease			Fainting		
Tuberculosis			Convulsions		
Jaundice			Blackouts		
Sickle-Cell Anemia					
<b>Please detail any specific medical information including current medications and allergies:</b>					
I understand, due to Health Insurance Portability & Accountability Act HIPAA, that information regarding my child is confidential. To ensure the best outcome for my child, this information may be shared with all school personnel.					
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Mother Signature: _____			Date: _____		
Father Signature: _____			Date: _____		

**INSURANCE STATEMENT**

*Our son / daughter will comply with the specific insurance regulations of the school.*

Family Insurance Co. \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

**MEDICAL TREATMENT CONSENT - To be completed by Parent or Guardian**

I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstances and to assume the expenses of such care.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_ DATE \_\_\_\_\_

**CONSENT - To be completed by Parent or Guardian**

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/she has my permission to accompany the team as a member on its out-of-town trips. I further understand that my son or daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**EMERGENCY INFORMATION - To be completed by Parent or Guardian**

**IN EMERGENCY CALL**

1) \_\_\_\_\_ Phone: \_\_\_\_\_

2) \_\_\_\_\_ Phone: \_\_\_\_\_

My family doctor is: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Parents of children 2½ years to school age shall provide this health appraisal form signed by a licensed physician or his or her designee that a physical evaluation has been made within the preceding one year. Activity restrictions shall be noted. A current year physical is one given on or after April 15 of the previous school year.

**PHYSICAL EXAMINATION**

To be completed by the examining MD, DO, Physician's Assistant or Nurse Practitioner & returned directly to the patient. (Categories may be added or deleted; check appropriate column.)

SYSTEM	NORMAL	ABN.
Urinalysis		
Vision		
Blood Pressure		
Pulse Rate		
Ears		
Nose		
Throat		
Teeth - Cavities		
Orthopedic		
Weight		

SYSTEM	NORMAL	ABN.
Thyroid		
Chest		
Lungs		
Heart		
Abdomen		
Hernia		
Genitalia/Testicular Exam		
Neurologic		
Muscular		

**TESTS AND MEASUREMENTS**

	Yes	No	Normal	Under Care	Referred
Vision Tested					
Visual Activity					
Ocular Muscle					
Other					
Date					
Hearing Tested					
Audiometer					
Other					
Date					
Hemoglobin/ Hematocrit Tested?					
Urinalysis Done?					
Sugar					
Albumin					
Microscopic					
Date					
Blood Pressure Measured?					
Reading					

Height	
Weight	
Other	

**VACCINATIONS**

VACCINES *	DATE ADMINISTERED	
	Type	Mo/Day/Yr
Hepatitis B (Hep B)	1	
	2	
	3	
DtaP/DTP/DT/Td/Tdap (specify type)	1	5
	2	6
	3	7
	4	8
Haemophilus Influenza type b (HIB)	1	
	2	
	3	
Polio (IPV/OPV) (specify type)	1	3
	2	4
Pneumococcal Conjugate (PCV7)	1	3
	2	4
Rotavirus (RV)	1	2
	2	

VACCINES	DATE ADMINISTERED	
	Type	Mo/Day/Yr
Measles, Mumps, Rubella (MMR)	1	2
	1	
Varicella (chickenpox) If yes, date:		
Hepatitis A (Hep A)	1	2
Influenza	1	2
	3	4
Meningococcal MCV4/MPSV4 (specify type)	1	2
	History of Chickenpox Disease? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other Vaccines: (Specify date & type)		

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

**RECOMMENDATIONS:**

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below:

BASEBALL - BASKETBALL - CROSS COUNTRY - EQUESTRIAN - FIGURE SKATING - FOOTBALL - GOLF - GYMNASTICS  
ICE HOCKEY - LACROSSE - POM - SKIING - SOCCER - SOFTBALL - SWIMMING - TENNIS - TRACK - VOLLEYBALL

SIGNATURE OF EXAMINER: \_\_\_\_\_ DATE \_\_\_\_\_

PRINTED NAME OF EXAMINER: \_\_\_\_\_ DATE \_\_\_\_\_

CIRCLE ONE:  
MD DO PA NP

\*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.