

St. Mary's Daycare Center  
 2912 W. M-113  
 Kingsley, MI 49649  
 231-263-7560

Child's Health Appraisal

Today's date \_\_\_\_\_

Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parents' or guardians' names \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Information provided by: (check one) Parent \_\_\_\_\_ Guardian \_\_\_\_\_ Physician \_\_\_\_\_ Nurse \_\_\_\_\_

<i>Is your child having any of the problems listed below?</i>	Yes	No
1. Hay fever, asthma or wheezing		
2. Eczema or frequent skin rashes		
3. Convulsion/Seizures		
4. Heart Trouble		
5. Diabetes		
6. Frequent colds, sore throats, earaches (4 or more per year)		
7. Trouble with passing urine or bowel movements		
8. Shortness of breath		
9. Speech problems		
10. Other		
11. Allergies or reactions: (food, medication or other)		
Please explain any problem areas identified above:		
Does your child take any medication regularly?		
If yes, what medication?		
Reason for medication:		
Parent's signature:		

DTP/DT/TD Mo/Day/Yr	Polio OPV/IPV Mo/Day/Yr	Hepatitis B Mo/Day/Yr
1	1	1
2	2	2
3	3	3
4	4	
5	5	
6		
7		HIB
		Mo/Day/Yr
Varicella (Chicken Pox)	MMR	1
	Mo/Day/Yr	2
Had Chicken Pox? Yes No	1	3
Had Vaccine? When?	2	4

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Validating Signature

Title

Date

Recommendations – **COMPLETED BY A PHYSICIAN**

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 \_\_\_\_\_ other \_\_\_\_\_

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Examiner's signature

Degree or license

Date

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Examiner's name (print or type)