EXHIBIT (INITIAL PHYSICAL)

See Reverse Side For Yearly Physical Record.

YOUTH HEALTH RECORD
INITIAL PHYSICAL
State of Michigan Department of Human Services

Authority: P.A. 116 of 1973.
Completion: Is required.
Consequence for non-completion: Non-compliance of licensing rules.

PERSONAL

Child's Name (Last, First, Middle)		Sex	Date of Birth	Today's Date
Address (Number & Street)	City		State	Zip Code
Parent's or Guardian's Name (Last, First, Middle)			Telephone (Home)	Telephone (Work)
Address (Number & Street)	City		State	Zip Code

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, ear aches (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(s) _____	☐	☐
	☐	☐

Please explain any problem areas identified above:

Does your child take any medication regularly?

☐ YES (Explain) _____

☐ NO

Reason for Medication

Parent's Signature

SECTION II – IMMUNIZATION(S)

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:
DTP/DT/Td DTaP (Specify Type)		1.		6
		2.		7.
		3.		8.
		4		9
		5.		10.
Haemophilus influenzae type b (HIB)		1.		3.
		2.		4.
POLIO (Specify Type) OPV / IPV		1.		4.
		2.		5.
		3.		

Note: If Measles, Rubella, or Mumps vaccines were given before 12 months of age, the dosage must be repeated.

	Mo/Day/Yr:	Mo/Day/Yr:
MMR	1.	2.
Varicella (Chickenpox)	1.	
	2.	
Hepatitis B	1.	3.
	2.	
Pneumococcal Conjugate (PCV)	1.	3.
	2.	4.
Other Vaccines		

Indicate physician diagnosis of disease 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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

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EXHIBIT (YEARLY PHYSICAL)

YEARLY PHYSICAL

SECTION III - PERSONAL

Child's Address (Number & Street, City, State, Zip Code)		Today's Date
Parent's or Guardian's Name (Last, First, Middle)	Telephone (Home)	Telephone (Work)
Parent's Address (Number & Street, City, State, Zip Code)		

SECTION IV – TESTS AND MEASUREMENTS

TEST TYPE	NO	YES	DATE TESTED	WEIGHT: LBS. / HEIGHT: Ft. In.	NORMAL	UNDER CARE	REFERRED
VISION	☐	☐		☐ Visual Acuity ☐ Ocular Muscle ☐ Other	☐	☐	☐
HEARING	☐	☐		☐ Audio-meter ☐ Other	☐	☐	☐
HEMOGLOBIN/ HEMATOCRIT	☐	☐			☐	☐	☐
URINALYSIS	☐	☐		☐ Sugar ☐ Albumin ☐ Microscopic	☐	☐	☐
BLOOD PRESSURE	☐	☐		Reading	☐	☐	☐
TUBERCULIN	☐	☐		Type / Results ☐ Positive ☐ Negative	mm.		
OTHER (Specify) ▶							
OTHER (Specify) ▶							

Essential findings deviating from normal and/or recommendations

SECTION V - RECOMMENDATIONS

DATE	EXAM TYPE AND RESULTS	CLINIC'S NAME AND EXAMINER'S NAME
	Type / Results	Clinic / Examiner
	Type / Results	Clinic / Examiner
	Type / Results	Clinic / Examiner
	Type / Results	Clinic / Examiner
	Type / Results	Clinic / Examiner

Is there any defect of vision, hearing or other condition for which the school could help by seating or other action?
☐ NO ☐ YES ▶ If Yes, explain below.

Explanation:

Should the student's activity be restricted because of any physical defects or illness?
☐ NO ☐ YES ▶ If Yes, explain below.

Restriction:
☐ Classroom ☐ Gymnasium ☐ Competitive Sports
☐ Playground ☐ Swimming Pool ☐ Camp
☐ Other (Specify)

Explain Degree of Restriction:

EXAMINER'S SIGNATURE DATE

Examiner's Name (Print or Type)	Degree or License	Telephone Number	
Address (Street Number and Name)	City	State	Zip Code

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