

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf
- **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: <http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf>

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M ☐ F ☐	
Address: _____ Last First Middle			Mo / Day / Yr			
Number Street		Apt#	City		State	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)			
		W:	C:	H:		
		W:	C:	H:		
Where do you usually take your child for routine medical care? Name: _____						
Address: _____			Phone Number: _____			
When was the last time your child had a physical exam? Month: _____ Year: _____						
Where do you usually take your child for dental care? Name: _____						
Address: _____			Phone Number: _____			
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.						
	Yes	No	Comments (required for any Yes answer)			
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐				
Allergies (Seasonal)	☐	☐				
Asthma or Breathing	☐	☐				
Behavioral or Emotional	☐	☐				
Birth Defect(s)	☐	☐				
Bladder	☐	☐				
Bleeding	☐	☐				
Bowels	☐	☐				
Cerebral Palsy	☐	☐				
Coughing	☐	☐				
Developmental Delay	☐	☐				
Diabetes	☐	☐				
Ears or Deafness	☐	☐				
Eyes or Vision	☐	☐				
Head Injury	☐	☐				
Heart	☐	☐				
Hospitalization (When, Where)	☐	☐				
Lead Poisoning/Exposure	☐	☐				
Life Threatening Allergic Reactions	☐	☐				
Limits on Physical Activity	☐	☐				
Meningitis	☐	☐				
Prematurity	☐	☐				
Seizures	☐	☐				
Sickle Cell Disease	☐	☐				
Speech/Language	☐	☐				
Surgery	☐	☐				
Other	☐	☐				
Does your child take medication (prescription or non-prescription) at any time?						
☐ No ☐ Yes, name(s) of medication(s): _____						
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)						
☐ No ☐ Yes, type of treatment: _____						
Does your child require any special procedures? (catheterization, G-Tube, etc.)						
☐ No ☐ Yes, what procedure(s): _____						
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.						
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.						
Signature of Parent/Guardian _____						Date _____

PART II - CHILD HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Child's Name:				Birth Date:				Sex	
Last		First		Middle		Month / Day / Year		M ☐ F ☐	
1. Does the child named above have a diagnosed medical condition? ☐ No ☐ Yes, describe:									
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card. ☐ No ☐ Yes, describe:									
3. PE Findings									
Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated		
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐		
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐		
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐		
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐		
Dental	☐	☐	☐	Nutrition	☐	☐	☐		
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐		
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐		
ENT	☐	☐	☐	Respiratory	☐	☐	☐		
GI	☐	☐	☐	Skin	☐	☐	☐		
GU	☐	☐	☐	Speech/Language	☐	☐	☐		
Hearing	☐	☐	☐	Vision	☐	☐	☐		
Immunodeficiency	☐	☐	☐	Other:	☐	☐	☐		
REMARKS: (Please explain any abnormal findings.)									
4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmmh.maryland.gov/IMMUN/pdf/896_form.pdf)									
RELIGIOUS OBJECTION:									
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.									
Parent/Guardian Signature: _____ Date: _____									
5. Is the child on medication? ☐ No ☐ Yes, indicate medication and diagnosis: (OCC 1216 Medication Authorization Form must be completed to administer medication in child care).									
6. Should there be any restriction of physical activity in child care? ☐ No ☐ Yes, specify nature and duration of restriction:									
7. Test/Measurement			Results				Date Taken		
Tuberculin Test									
Blood Pressure									
Height									
Weight									
BMI %tile									
Lead Test Indicated: ☐ Yes ☐ No									

(Child's Name) has had a complete physical examination and any concerns have been noted above.

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age.

If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

Allegany	Baltimore (cont)	Cecil	Garrett	Montgomery	Prince George's	St. Mary's
ALL	21220	21913	ALL	20783	(cont)	20606
	21221			20787		20626
Anne Arundel	21222	Charles	Harford	20812	20783	20628
20711	21224	20640	21001	20815	20784	20674
20714	21227	20658	21010	20816	20785	20687
20764	21228	20662	21034	20818	20787	
20779	21229		21040	20838	20788	Talbot
21060	21234	Dorchester	21078	20842	20790	21612
21061	21236	ALL	21082	20868	20791	21654
21225	21237		21085	20877	20792	21657
21226	21239	Frederick	21130	20901	20799	21665
21402	21244	20842	21111	20910	20912	21671
	21250	21701	21160	20912	20913	21673
Baltimore	21251	21703	21161	20913		21676
21027	21282	21704			Queen Anne's	
21052 *	21286	21716	Howard	Prince George's	21607	Washington
21071		21718	20763	20703	21617	ALL
21082	Baltimore City	21719		20710	21620	
21085	ALL	21727	Kent	20712	21623	Wicomico
21093		21757	21610	20722	21628	ALL
21111	Calvert	21758	21620	20731	21640	
21133	20615	21762	21645	20737	21644	Worcester
21155	20714	21769	21650	20738	21649	ALL
21161		21776	21651	20740	21651	
21204	Caroline	21778	21661	20741	21657	
21206	ALL	21780	21667	20742	21668	
21207		21783		20743	21670	
21208	Carroll	21787		20746		
21209	21155	21791		20748	Somerset	
21210	21757	21798		20752	ALL	
21212	21776			20770		
21215	21787			20781		
21219	21791					