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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896

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: <u>http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf</u>

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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.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 co	mpleted by	y parent or	quardian
			gaar aran

Last Pint Middle Middle Number Sinset Asse City Sinset Zp Parent/Guardian Name(s) Relationship Phone Number(s) Phone Number(s) Phone Number(s) Your Child's Routine Medical Care Provider W: C: H: Name: Asses Asses Phone Number(s) Address: Phone Number(s) Phone Number(s) Phone Number(s) Address: Address: Phone Number(s) Phone Number(s) Address: Phone Number(s) Phone Number(s) Phone Number(s) </th <th>Child's Name:</th> <th></th> <th></th> <th></th> <th>Birth date:</th> <th>Sex</th>	Child's Name:				Birth date:	Sex
Number State Zp Parent/Guardan Name(s) Relationship W: C: H: Vour Child's Routine Medical Care Provider W: C: H: H: Name: Na	Last		First	t Middle		Mo/Day/Yr M□F□
Parent/Guardian Name(s) Relationship Phone Number(s) V: C: H: Vuor Child's Routine Medical Care Provider Vir, C: H: Vour Child's Routine Medical Care Provider Vir, C: H: Name: Name: C: H: Address: Phone B Denial Care: Phone Name: Address: Phone Name: Denial Care: Phone Name: Address: Phone Name: Comments (required for any Yes answer) Allergies (Road: Insects, Drugs, Latex, etc.) D Comments (required for any Yes answer) Allergies (Road: Insects, Drugs, Latex, etc.) D Comments (required for any Yes answer) Allergies (Road: Insects, Drugs, Latex, etc.) D Comments (required for any Yes answer) Baladur D D Comments (required for any Yes answer) Baladur D D Comments (required for any Yes answer) Comments (required for any Yes answer) D D Baladur D D Comments (required for any Yes answer) Baladur D	Address:					
W: C: H: Your Child's Routine Medical Care Provider Address: Prove Child's Routine Dental Care Provider Phone # Prove # <td>Number Street</td> <td></td> <td></td> <td>Apt# City</td> <td></td> <td>State Zip</td>	Number Street			Apt# City		State Zip
Your Child's Routine Medical Care Provider Name: Address: H: Last Time Child Sees for Psyckal Earn: Destal Care: Psyckal Earn: Psyckal Earn: Destal Care: Psyckal Earn: Destal Care: Psyckal Earn: Destal Care: Psyckal Earn: Destal Care: Psyckal Earn: Destal Care: Psyckal Earn: Psyckal Earn: Destal Care: Psyckal Earn: Destal Care: Psyckal Earn: Psyckal E	Parent/Guardian Name(s)	Relatio	onship			-
Your Child's Routine Medical Care Provider Name: Address: Your Child's Routine Dental Care Provider Name: Address: Last Time Child Seen for Mpplical Earn: Address: Address: Name: Address: Address: Any Special St. Any Special St. Any Special St. Any Special St. Address: Address: Name: Address: Any Special St. Any Special St. Address: Any Special St. Any Special St. Any Special St. Any Special St. Any Special St. Address: Any Special St. Any Special St. Any Special St. Address: Allergies (Resonal)					-	H:
Name: Name: Phone Phone <th< td=""><td></td><td></td><td></td><td>W:</td><td>C:</td><td>H:</td></th<>				W:	C:	H:
Address: Denu Denu Denu Denu 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. Image: Comments (required for any Yes answer) Allergies (Focasonal) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Allergies (Focasonal) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Allergies (Focasonal) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Allergies (Focasonal) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Allergies (Focasonal) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Bedder Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Bedder Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Image: Comments (required for any Yes answer) Delevelopmental Delay	Your Child's Routine Medical Care Provide	r		Your Child's Routine Dental	Care Provider	Last Time Child Seen for
Phone Invoce Anv Specialiti: SSESSMENT 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. Image of the following? Check Yes or No and provide a comment for any YES answer. Allergies (Food, Insects, Drugs, Latex, etc.) Image of the following? Image of the following? Allergies (Seasonal) Image of the following? Image of the following? Image of the following? Allergies (Seasonal) Image of the following? Image of the following? Image of the following? Image of the following? Bladder Image of the following? Image of the following? Image of the following? Image of the following? Bladder Image of the following? Image of the following? Image of the following? Image of the following? Bladder Image of the following? Image of the following? <td< td=""><td>Name:</td><td></td><td></td><td colspan="3"></td></td<>	Name:					
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 (Foad, Inseds, Drugs, Latex, etc.)						
provide a comment for any YES answer. New Comments (required for any YES answer) Allergies (Food, Insects, Drugs, Latex, etc.) Image: Comments (required for any YES answer) Allergies (Food, Insects, Drugs, Latex, etc.) Image: Comments (required for any YES answer) Backder Image: Comments (required for any YES answer) Backder Image: Comments (required for any YES answer) Bidder Image: Comments (required for any YES answer) Developmental Delay Image: Comments (required for answer) Developmental Delay <thimage: (required="" answer)<="" commental="" for="" td=""><td></td><td>o host o</td><td>f vour kno</td><td></td><td>arablem with the following? Ch</td><td></td></thimage:>		o host o	f vour kno		arablem with the following? Ch	
Yes No Comments (required for any Yes answer) Allergies (Seasonal)		ie best o		wieuge has your child had any p		IECK TES OF NO ANU
Allergies (Food, Insexts, Drugs, Latex, etc.)		Yes	No	Comme	nts (required for any Yes ans	wer)
Allergies (Seasonal)	Allergies (Food, Insects, Drugs, Latex, etc.)					,
Astima or Breathing						
Bith Defect(s)						
Bieder Image: Comparison of the second s	Behavioral or Emotional					
Bleeding Image: Coupling Image: Coupling Image: Coupling Coupling Image: Coupling Image: Coupling Image: Coupling Peeding Image: Coupling Image: Coupling Image: Coupling Image: Coupling Feeding Image: Coupling	Birth Defect(s)					
Bowels						
Cerebral Palsy	Bleeding					
Coughing	Bowels					
Communication	Cerebral Palsy					
Developmental Delay	Coughing					
Diabetes	Communication					
Ears or Deafness	Developmental Delay					
Eyes or Vision	Diabetes					
Feeding	Ears or Deafness					
Head Injury Image: Control of the second	Eyes or Vision					
Heart Image: Control of the control	Feeding					
Hospitalization (When, Where) Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Life Threatening Allergic Reactions Image: Complete DHMH4620 Image: Complete DHMH4620 Meinigitis Image: Complete DHMH4620 Image: Complete DHMH4620 Image: Complete DHMH4620 Meinigitis Image: Complete DHMH4620 Image: Complete DHMH4620 Image: Complete DHMH4620 Mobility-Assistive Devices if any Image: Complete DHMH4620 Image: Complete DHMH4620 Image: Complete DHMH4620 Starters Image: Complete DHMH4620 Image: Complete DHMH4620 Image: Complete DHMH4620 Image: Complete DHMH4620 Starters Image: Complete DHMH4620 Image: Complete DHM4620 <td>Head Injury</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Head Injury					
Lead Poison/Exposure complete DHMH4620	Heart					
Life Threatening Allergic Reactions						
Limits on Physical Activity	Lead Poison/Exposure complete DHMH4620					
Meningitis Image: Construction of the second se	Life Threatening Allergic Reactions					
Mobility-Assistive Devices if any	Limits on Physical Activity					
Prematurity	Meningitis					
Seizures Image: Ima	Mobility-Assistive Devices if any					
Sickle Cell Disease Image: Construction of the second	Prematurity					
Speech/Language	Seizures					
Surgery Image: Content in the image: Conte	Sickle Cell Disease					
Other Image: Control of the content	Speech/Language					
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition? No Yes, name(s) of medication(s): Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) No Yes, type of treatment: Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.	Surgery					
No Yes, name(s) of medication(s): Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) No Yes, type of treatment: Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.						
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) No Yes, type of treatment: Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.	Does your child take medication (prescript	tion or n	on-presc	ription) at any time? and/or for	r ongoing health condition?	
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) No Yes, type of treatment: Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.	\square No \square Yes name(s) of medication(s)	s).				
No Yes, type of treatment: Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.		,				
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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.	Does your child receive any special treatm	ents? (I	Nebulizer,	EPI Pen, Insulin, Counseling 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. 	☐ No ☐ Yes, type of treatment:					
 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. 	Does your child require any special proces	luros 2 (l	Irinary Ca	theterization G-Tube feeding]	Fransfer etc.)	
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.			Jinary Ca	interenzation, G-Tube reeding, T	ransier, etc.)	
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.	☐ No ☐ Yes, what procedure(s):					
AND BELIEF.			-			IDERSTAND IT IS
AND BELIEF.						
			I HIS	FURINIS INUE AND ACC	URALE IN THE BEST OF	
Signature of Parent/Guardian Date	AND DELIEF.					
Signature of Parent/Guardian Date						
	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	Мо	nth / Day / Year		
1. Does the child named above ha	ave a diagnos	ed medical c	ondition?		•	-		
No Yes, describe:								
2. Does the child have a health of bleeding problem, diabetes, h								
□ No □ Yes, describe:								
3. PE Findings								
Health Area	WNL	ABNL	Not Evaluated	Health Ar	202	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity					osure/Elevated Lead			
Behavior/Adjustment				Mobility				
Bowel/Bladder				· · · ·	keletal/orthopedic			
Cardiac/murmur				Neurologi				
Dental				Nutrition				
Development				Physical I	Iness/Impairment			
Endocrine				Psychoso				
ENT				Respirato	ry			
GI				Skin	•			
GU				Speech/L	anguage			
Hearing				Vision				
Immunodeficiency				Other:				
 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 <u>or</u> a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896february_2014.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 nati	ure and durati	on of restrict	ion:					
7. Test/Measurement Tuberculin Test		Results			Da	ite Taken		
Blood Pressure								
Height								
Weight								
BMI %tile								
LeadTest Indicated:DHMH 4620 [🗌 Yes 🗖	O Test #1		Test	#2 Tes	st # 1	Test #2	
(Child's Name)	has ha	d a comp	lete physic	al examir	nation and any	concerns hav	e been n	oted above.

Additional Comments:

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