

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select 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:
<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/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

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 <input type="checkbox"/> F <input type="checkbox"/>	
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.)	<input type="checkbox"/>	<input type="checkbox"/>				
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>				
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>				
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>				
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>				
Bladder	<input type="checkbox"/>	<input type="checkbox"/>				
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>				
Bowels	<input type="checkbox"/>	<input type="checkbox"/>				
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>				
Coughing	<input type="checkbox"/>	<input type="checkbox"/>				
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>				
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>				
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>				
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>				
Heart	<input type="checkbox"/>	<input type="checkbox"/>				
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>				
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>				
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>				
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>				
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>				
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>				
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>				
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>				
Surgery	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>				
Does your child take medication (prescription or non-prescription) at any time?						
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____						
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____						
Does your child require any special procedures? (catheterization, G-Tube, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> 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
<div style="display: flex; justify-content: space-between;"> Last First Middle </div>	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html) Select DHMH 896.

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: <input type="checkbox"/> Yes <input type="checkbox"/> 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 ALL	Baltimore (cont) 21220	Cecil 21913	Garrett ALL	Montgomery 20783	Prince George's (cont)	St. Mary's 20606
	21221			20787	20782	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					

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 ADDRESS CITY STATE ZIP
 SEX: ☐ MALE ☐ FEMALE BIRTHDATE _____ / _____ / _____
 COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN _____ / _____ / _____
 LAST FIRST MIDDLE PHONE
 ADDRESS _____ / _____ / _____
 CITY STATE ZIP

CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003, the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

RECORD OF BLOOD LEAD TESTING

Test #1. _____ Test #2. _____ Comments: _____
Date Date

Signature _____ / _____
Health Care Provider or Designee OR School Health Professional or Designee Date

RECORD OF BLOOD LEAD TESTING EXEMPTION

I, _____ certify that my child does not AND has never resided in an at-risk area.
Parent or Guardian (Print)

Signature _____ / _____
Parent or Guardian Date

COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed _____ / _____
Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed _____ / _____
Health Care Provider Date