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_-_february_2014.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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.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://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 completed by parent or guardian

**Child's Name:** _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

**Address:** _____
Number Street Apt# City State Zip

| Parent/Guardian Name(s) | Relationship | Phone Number(s) | | |
|---|---|---|---|---|
| | | W: | C: | H: |
| | | W: | C: | H: |

| Your Child's Routine Medical Care Provider | Your Child's Routine Dental Care Provider | Last Time Child Seen for |
|---|---|---|
| **Name:** | **Name:** | **Physical Exam:** |
| **Address:** | **Address:** | **Dental Care:** |
| **Phone #** | **Phone** | **Any Specialist :** |

**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 | ☐ | ☐ | |
| Communication | ☐ | ☐ | |
| Developmental Delay | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Ears or Deafness | ☐ | ☐ | |
| Eyes or Vision | ☐ | ☐ | |
| Feeding | ☐ | ☐ | |
| Head Injury | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Hospitalization (When, Where) | ☐ | ☐ | |
| Lead Poison/Exposure complete DHMH4620 | ☐ | ☐ | |
| Life Threatening Allergic Reactions | ☐ | ☐ | |
| Limits on Physical Activity | ☐ | ☐ | |
| Meningitis | ☐ | ☐ | |
| Mobility-Assistive Devices if any | ☐ | ☐ | |
| Prematurity | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |
| Sickle Cell Disease | ☐ | ☐ | |
| Speech/Language | ☐ | ☐ | |
| Surgery | ☐ | ☐ | |
| Other | ☐ | ☐ | |

**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.**

_____ _____
Signature of Parent/Guardian Date