

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											
Last			First			Middle			Mo / Day / Yr			M <input type="checkbox"/> F <input type="checkbox"/>					
Address: _____																	
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: <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Last First Middle </div>			Birth Date: <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Month / Day / Year </div>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
1. Does the child named above have a diagnosed medical condition? <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> 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://ideha.dhmh.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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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:
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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 21221	Cecil 21913	Garrett ALL	Montgomery 20783 20787	Prince George's (cont) 20782 20783	St. Mary's 20606 20626
Anne Arundel 20711 20714 20764 20779 21060 21061 21225 21226 21402	21222 21224 21227 21228 21229 21234 21236 21237 21239 21244 21250 21251	Charles 20640 20658 20662	Harford 21001 21010 21034 21040 21078 21082 21085 21130 21111 21160 21161	20812 20815 20816 20818 20838 20842 20868 20877 20901 20910 20912 20913	20784 20785 20787 20788 20790 20791 20792 20799 20912 20913	20628 20674 20687
Baltimore 21027 21052 21071 21082 21085 21093 21111 21133 21155 21161 21204 21206 21207 21208 21209 21210 21212 21215 21219	Baltimore City ALL Calvert 20615 20714 Caroline ALL Carroll 21155 21757 21776 21787 21791	Dorchester ALL Frederick 20842 21701 21703 21704 21716 21718 21719 21727 21757 21758 21762 21769 21776 21778 21780 21783 21787 21791 21798	Howard 20763 Kent 21610 21620 21645 21650 21651 21661 21667	Prince George's 20703 20710 20712 20722 20731 20737 20738 20740 20741 20742 20743 20746 20748 20752 20770 20781	Queen Anne's 21607 21617 21620 21623 21628 21640 21644 21649 21651 21657 21668 21670 Somerset ALL	Talbot 21612 21654 21657 21665 21671 21673 21676 Washington ALL Wicomico ALL Worcester ALL