MARYLANDSTATEDEPARTMENTOFEDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUESED 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 is 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.odf
- ***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:* **Error! Hyperlink reference not valid.**

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.

INSTUCTIONS

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/occl216-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**

Last First Middle Mo / Day / Yr M☐F☐

Address: _____

Number Street Apt# City State Zip

Parent/Guardian **Name(s)**	Relationship	Phone Number(s)	
		W: **IC**:	H:
		W: **IC**:	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 DI-Ilv1H4620			
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 _____

PART 11 - CHILD HEALTH ASSESSMENT

To be completed *ONLY* By Physician/Nurse Practitioner

Child's Name: _____ (Last / First / Middle) | Birth Date: _____ (Month / Day / Year) | Sex MO FD

1. Does the child named above have a diagnosed medical condition?

☐No D 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.

0 **No** D Yes, describe:

3. PE Findin"s

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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland immunization certification form DHMH 896 - February 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 D Yes, indicate medication and diagnosis:

(0CC 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: DHMH 4620 ☐Yes ☐No	Test#l Test#2	Test# 1 Test #2

_____ has had a complete physical examination and any concerns have been noted above.

(Child's Name)

Additional Comments: ----------

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B,** also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX Dis** for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ I _____ I _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ I _____ I _____ I _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ☐Male ☐Female BIRTHDATE I I PHONE _____

PARENT OR GUARDIAN _____ I _____ I _____
LAST FIRST MIDDLE

BOX B-For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ☐ YES ☐ NO

Has this child ever lived in one of the areas 1isted on the back of this form? ☐ YES ☐ NO

Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ☐ YES ☐ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ Signature: _____ **Date:** _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C -Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Tvpe (V=venous, C=canillarv)	Result !mc /dL)	Comments

Comments:

Person completing form: ☐Health Care Provider/Designee OR ☐School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D -Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: D YES ☐**NO**

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan *(for* children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St.Ma[Y'S
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CIDLD'S NAME _____
LAST FIRST MI

SEX: MALE☐ FEMALE☐ BIRTHDATE ____/____/____

COUNTY SCHOOL GRADE

PARENT OR GUARDIAN NAME _____ PHONENO. _____

ADDRESS _____ CITY _____ ZIP __

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose#	DTP-DTaP-DT Mo/Day/Yr	Pollo Mo/DayMr	Hib M□!Day/Yr	Hepa Mo/Day/Yr	PCV Mo/Day/Yr	Rotavlrus Mo/Day/Yr	MCV Mo!Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo!Day/Yr	MMR Mo/Day/Yr	Varlce)la Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/DayNr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										--	--	--	
5										--	--	--	
										--			

To the best of my knowledge, the vaccines listed above were administered as indicated,

Clinic/ Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: D Permanent condition OR D Temporary condition until-- /____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

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 vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from another record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in anyway.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or parents (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**

s. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Hemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-approp1iate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and G) Tetanus-diphtheria-acellularpertussiB acquired through a Tetanus-diphtheria-acellularpertussis (Tdap) vaccine."

Please refer to the **"Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and iu Schools"** to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements arid DHJ\1H COMAR 10. 06.04.03 are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.dhmh.maryland.gov. (Choose immunization in the A-Z Index)