

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: Wojtowicz, Adelyn Yvonne Birth date: 11/18/2014 Sex M F
Last First Middle Mo / Day / Yr

Address: 3811 Gelding Lane, Olney, MD 20892
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)	
Isabella Gallis	Mother	W: 301-594-8135	C: 240-997-6631
Daniel Wojtowicz	Father	W:	C: 240-644-9263

Your Child's Routine Medical Care Provider Name: <u>Dr. Melvin Stern</u> Address: <u>6685 Mink Hollow Rd, Highland, Md</u> Phone #: <u>301-854-3444</u>	Your Child's Routine Dental Care Provider Name: Address: Phone:	Last Time Child Seen for Physical Exam: <u>11/2019</u> Dental Care: Any Specialist:
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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 checked="" type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Behavioral or Emotional	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Birth Defect(s)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Bladder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Bowels	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Communication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Heart	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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.

Isabella Gallis 11/23/2020
 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	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		
LeadTest Indicated:DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1 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:
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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 D** is 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 _____ / _____ / _____
 CHILD'S ADDRESS _____ LAST _____ FIRST _____ MIDDLE _____
 STREET ADDRESS (with Apartment Number) _____ CITY _____ STATE _____ ZIP _____
 SEX: Male Female BIRTHDATE _____ / _____ / _____ PHONE _____
 PARENT OR GUARDIAN _____ / _____ / _____
 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 listed 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	Type (V=venous, C=capillary)	Result (mcg/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: YES NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

