

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 | |
| _____ 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: _____ | |
| | | | | W: _____ | | C: _____ | |
| Your Child's Routine Medical Care Provider | | | | Your Child's Routine Dental Care Provider | | Last Time Child Seen for Physical Exam: | |
| Name: _____ | | | | Name: _____ | | Dental Care: _____ | |
| Address: _____ | | | | Address: _____ | | Any Specialist: _____ | |
| Phone # _____ | | | | Phone _____ | | | |
| 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"/> | | | | | |
| Communication | <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"/> | | | | | |
| Feeding | <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 Poison/Exposure complete DHMH4620 | <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"/> | | | | | |
| Mobility-Assistive Devices if any | <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? and/or for ongoing health condition? | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____ | | | | | | | |
| Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____ | | | | | | | |
| Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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 |
| 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmm_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 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: 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: |
| | | | |

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 _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 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: _____

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)

| <u>Allegany</u> | <u>Baltimore Co. (Continued)</u> | <u>Carroll</u> | <u>Frederick (Continued)</u> | <u>Kent</u> | <u>Prince George's (Continued)</u> | <u>Queen Anne's (Continued)</u> |
|----------------------|--------------------------------------|-------------------|----------------------------------|------------------------|----------------------------------------|-------------------------------------|
| ALL | 21212 | 21155 | 21776 | 21610 | 20737 | 21640 |
| | 21215 | 21757 | 21778 | 21620 | 20738 | 21644 |
| <u>Anne Arundel</u> | 21219 | 21776 | 21780 | 21645 | 20740 | 21649 |
| 20711 | 21220 | 21787 | 21783 | 21650 | 20741 | 21651 |
| 20714 | 21221 | 21791 | 21787 | 21651 | 20742 | 21657 |
| 20764 | 21222 | | 21791 | 21661 | 20743 | 21668 |
| 20779 | 21224 | <u>Cecil</u> | 21798 | 21667 | 20746 | 21670 |
| 21060 | 21227 | 21913 | | | 20748 | |
| 21061 | 21228 | | <u>Garrett</u> | <u>Montgomery</u> | 20752 | <u>Somerset</u> |
| 21225 | 21229 | <u>Charles</u> | ALL | 20783 | 20770 | ALL |
| 21226 | 21234 | 20640 | | 20787 | 20781 | |
| 21402 | 21236 | 20658 | <u>Harford</u> | 20812 | 20782 | <u>St. Mary's</u> |
| | 21237 | 20662 | 21001 | 20815 | 20783 | 20606 |
| <u>Baltimore Co.</u> | 21239 | | 21010 | 20816 | 20784 | 20626 |
| 21027 | 21244 | <u>Dorchester</u> | 21034 | 20818 | 20785 | 20628 |
| 21052 | 21250 | ALL | 21040 | 20838 | 20787 | 20674 |
| 21071 | 21251 | | 21078 | 20842 | 20788 | 20687 |
| 21082 | 21282 | <u>Frederick</u> | 21082 | 20868 | 20790 | |
| 21085 | 21286 | 20842 | 21085 | 20877 | 20791 | <u>Talbot</u> |
| 21093 | | 21701 | 21130 | 20901 | 20792 | 21612 |
| 21111 | <u>Baltimore City</u> | 21703 | 21111 | 20910 | 20799 | 21654 |
| 21133 | ALL | 21704 | 21160 | 20912 | 20912 | 21657 |
| 21155 | | 21716 | 21161 | 20913 | 20913 | 21665 |
| 21161 | <u>Calvert</u> | 21718 | | | | 21671 |
| 21204 | 20615 | 21719 | <u>Howard</u> | <u>Prince George's</u> | <u>Queen Anne's</u> | 21673 |
| 21206 | 20714 | 21727 | 20763 | 20703 | 21607 | 21676 |
| 21207 | | 21757 | | 20710 | 21617 | |
| 21208 | <u>Caroline</u> | 21758 | | 20712 | 21620 | <u>Washington</u> |
| 21209 | ALL | 21762 | | 20722 | 21623 | ALL |
| 21210 | | 21769 | | 20731 | 21628 | |
| | | | | | | <u>Wicomico</u> |
| | | | | | | ALL |
| | | | | | | <u>Worcester</u> |
| | | | | | | 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.