MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____ _____
Last **First** **Middle** **Birth Date**

Name of Parent or Guardian _____ _____
Relationship

Home Address _____

City _____ **State** _____ **Zip Code** _____

Check Best Telephone Number to Reach You:

☐ **Home #:** _____ ☐ **Work #:** _____ ☐ **Cell #:** _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

_____
City/Town **State** **Zip Code**

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN** **CHILD'S NAME:** _____

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	____	____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	____	____
Date of last eye examination: ____/____/____ Doctor's Name: _____		
Results: _____		
Does your child wear glasses?	____	____
Contact lenses?	____	____
3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	____	____
Date of last hearing evaluation ____/____/____ Doctor's Name: _____		
Results: _____		
Does your child use a hearing aid?	____	____
4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.)*?	____	____
5. Does your child have any allergies? If YES, please state what kind of allergies:	____	____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:	____	____
(a) Does this condition require any special health care in the child care facility?	____	____
(b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?	____	____
(c) Does your child require any special adaptations or adaptive equipment?	____	____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	____	____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	____	____

REMARKS (*Provide further explanation for all "YES" answers):* _____

_____

_____

_____

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: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER** **CHILD'S NAME:** _____

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ____ Positive ____ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)

a. Vision problem	☐YES	☐ NO	_____
b. Hearing problem	☐YES	☐ NO	_____
c. Speech or language problem	☐YES	☐ NO	_____
d. Other physical illness or impairment	☐YES	☐ NO	_____
e. Mental, emotional or behavior problems	☐YES	☐ NO	_____
f. Developmental delays	☐YES	☐ NO	_____
g. Allergies	☐YES	☐ NO	_____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. ☐YES ☐ NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

☐YES ☐ NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. ☐YES ☐ NO

If YES, please specify: _____

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

_____

8. Does this child's physical activity need to be restricted? ☐YES ☐ NO

If YES, please specify: _____

9. Does this child require any specialized treatment? ☐YES ☐ NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? ☐YES ☐ NO

If YES, please specify type: _____

Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types Enter: Month/Day/Year for each immunization administered												
Dose #	**DTP-DTAP**	**Polio**	**HIB**	**Hep B**	**PCV7**	**MMR**	**Varicella**	**Rotavirus**	**MCV4**	**HPV**	**Hep A**	**Other**
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a ☐ permanent ☐ temporary condition until ___/___/___. Check appropriate box, indicate vaccine(s) and reasons: _____

_____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care.
(circle correct response)

_____ _____ _____
Signature of Health Practitioner **Date** **Phone Number**

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

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

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP DT-Td-Tdap Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Heb B Mo/Day/Yr	PCV7 Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV4 Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease
1									1				Mo/Yr
2									2				
3										Other	Other	Other	Other
4													
5													

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

Office Stamp

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.

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

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

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Physician or Health Officer

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.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per 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 any other 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 any way.

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 pertussis (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**.

5. 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 Haemophilus 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-appropriate 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; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.14.02.44 and COMAR 13A.14.01.29 DHR COMAR and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.EDCP.org (Immunization).