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			Deletional in
Home Address			Relationship
City		StateZi	p Code
Check Best Telephone Number to	Reach You:		Does your child have easy ear or hearing problems (P. Does vor the straining problems (P. J.
☐ Home #:		Ce	dl#:anass
			Does your child use a hearing said!
Dear Parent/Guardian:	nesenz hordilea gitresi	y having speeck unitary cool stammy take what kind of allergies:	Does your child have any speech problems (aifflound dynelogonous ere ?" Does your child have any allergoes? If YES, please a
	de physical examination		a doctor at regular intervals. The ich are necessary to keep your child
	ing your child, and med om your child's Health	ical information, lead s), which will be helpful to the creening/testing and proof of age-this information must be completed
six years of age have appro	priate screening for lea the State (see page 4) d	d poisoning. Children esignated as at-risk fo	zations and that children less than n who reside (or have ever or childhood lead poisoning <u>must</u>
PLEASE RETURN THIS COM			
Name of Child Care Facility:	ETILOF THIS FORM UNDERS	CTT TOMES TO COMPLETE PA	GIVE BY PRESENT FOR THE BEALTH PRA
Address:	AND RELLEK	EBEST OF MY RECOVERED	HIS FORM IS THUE AND A CYLERATE TO TH
City/Town		State	Zip Code

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION CHILD'S NAME: To be completed by PARENT/GUARDIAN 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: ____/ ____/ 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 ____/ ____/ 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 con	mpleted by a	HEALT	H PRAC	TITION	ER		CHIL	D'S NAME	:			
1. Date	of this chil	d's most re	ecent tube	rculin test	://	Resi	ult: P	ositive	Negati	ive		
Under M	Iaryland law	, a child u	nder the a	ge of six m	ust have ap	propriate se	reening/tes	ting for lead	d poisonin	g. See pag	ge 4.	
2. Date	of this chil	d's lead so	creening:			Blood lead	test dates:	Test 1:	//	Test	2:/	/
3. This	child has th	ne followin	ng which	may signif	icantly aff	ect his/her	child care e	xperience:		(COMME	ENTS)	
	ision probl				□YES			dida beruse				LDLLAM Lbatmbaro
b. F	Hearing prob	olem		(armedisa	□YES	□ NO						
c. S	peech or las	nguage pro	blem		□YES	□ NO						
d. C	Other physic	al illness o	or impairr	nent	□YES	□ NO	-					
	Aental, emo		ehavior p	roblems l	∃YES	□NO	fred Nurseal	valdan, Cott	gg la resolu	modes F-3	YT GO TYP	STAMPLERD
	Developmen	tal delays			□YES	□ NO	2 -111-1112-11-1					
-	Allergies				□YES	□ NO						
Sig	nificant phy	sical findi	ngs, comi	nents and	recommen	idations:						
4. This	child has a	health cor	ndition wl	nich may r	equire care	e or emerge	ncy action	while at ch	ild care.	\square YES	□ NO	
If Y	ES, please	specify (e	.g., seizur	es, bee stir	ng allergy,	diabetes, et	cc.):	N OTS IT ITS	PAGE ASSESSED.			
a a la	Li is and bys	l booki i sa Ia mi kulla	tesen from	Wolad-balk	ap codes la	dayer solde	ded, in say	SVE EVELTED	d to jabisa	orivi sunk	lien wellens	Loder Maryl
Rec	commendati	ons:										
	child has or											
										o a cilia c	care facility	or school.
	s child requi			_					\Box Y		□ NO	
If Y	YES, please	specify: _	13	E H	mel/	(1000 Apj. 10)	eril	House)	98	est saomali urcir	di RAR	AT RISK AV
7. If the	his child can	not fully p	articipate i	n all areas	of the child	d care progra	am, what ar	eas should b	e limited	or altered	to suit his/h	er needs?
1	2067	VII.	01	513	1	1095.12		21787		61212		eminally.
8. Do	es this child	's physical	activity 1	need to be	restricted?	Daving 2				YES	□NO	134
	YES, please	100										
	es this child					hodreE				YES		11705
		0.000	ñ 5 l						ш	LES	LI NO	52450C
	YES, please	510	nc		Sec. 1	OBJEC		Extent				
10. Do	es this child	d require a	ny adapti	ve equipm	ent (braces	s, crutches,	etc.)?			YES		1.515
If	YES, please	specify ty	pe:		- 451.24	58045 56975		District.		65.017		21226
Spe	ecial instruc	tions for u	se:	703	10	21135				REIL		<u>temoleši</u>
DT 60	ngaliji	(5)	mxox	ŠIĘI								
RECO	RD OF IN	MMUNIZ	LATION	<u>S</u>								
100	111	51.8		SATE		Vaccine Ty		200 YE		2. \$763° US	7	TORY C
Dose #	DTP-	Polio	HIB	Hep B	h/Day/Yea PCV7	r for each ir MMR	nmunizatio Varicella	n administe Rotavirus	red MCV4	HPV	Hep A	Other
	DTAP	833	11110	Перв	1017	D.ALC	- III	2.0		7 120c	Arep A	- Cinci
1		00.9	5.	200	3.0	2162U		21737		MINE		2115
2		15232	127	748	35	65361		25812		allena?		2120
3				UTE	25	21661		11778		3.37		2120
4						1805		11780				1212
5												

PART II: MEDICAL INFORMATION (CONTINUED)

		Child's Name	
MEDICAL CONTRAINDICATION: The above condition until/ Check appropriate by	child has a valid medical contraindi box, indicate vaccine(s) and reason	cation to being immunized at this t	ime. This is a permanent temporary
/ / Test 2: / /	d lead test dates. Test 1:	odfa \ \ \ :	Date of this child's lead screening
HEALTH PRACTITIONER'S STATEMEN conducted a physical examination of the above-	-named child and find that he/s	he IS / IS NOT med (circle correct response)	lically cleared to attend child care.
Signature of Health Practitioner	Date	Phone Number	d. Other physical illness or impair
STAMP, PRINT, OR TYPE: Name/address of Ph	ysician, Certified Nurse Practition	ner, Registered Physician's Assis	stant.

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	Baltimore (cont)	Carroll	Frederick(cont)	Montgomery	Prince	St. Mary's
BY	21210	21155	21783	20783	George's(cont)	20606
ZIP CODE	21212	21757	21787	20787	20782	20626
ZII CODE	21215	21776	21791	20812	20783	20628
Allegany	21219	21787	21798	20815	20784	20674
ALL	21220	21791		20816	20785	20687
THE	21221		Garrett	20818	20787	
Anne Arundel	21222	Cecil	ALL	20838	20788	Talbot
20711	21224	21913		20842	20790	21612
20714	21227		Harford	20868	20791	21654
20764	21228	Charles	21001	20877	20792	21657
20779	21229	20640	21010	20901	20799	21665
21060	21234	20658	21034	20910	20912	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237	20002	21078	20913	trequire any stape	21676
21226	21239	Dorchester	21082		Oueen Anne's	
21402	21244	ALL	21085	Prince George's	21607	Washington
Baltimore	21250	7 LLL	21130	20703	21617	ALL
21027	21251	Frederick	21111	20710	21620	
21052	21282	20842	21160	20712	21623	Wicomico
21071	21286	21701	21161	20722	21628	ALL
21082	21200	21703	21101	20731	21640	
21085	Baltimore City	21704	Howard	20737	21644	Worcester
21093	ALL	21716	20763	20738	21649	ALL
21111	ALL	21718	######################################	20740	21651	
21133	Calvert	21719	Kent	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204	20714	21758	21645	20746		
21204	Caroline	21762	21650	20748	Somerset	
21207	ALL	21769	21651	20752	ALL	
21207	ALL	21776	21661	20770		
21209		21778	21667	20781		
21209		21780	21007			

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

ex: male □	l FEMA		AST	BIRTHDA	TE	es eminor	FIRST /	nigh	ed and	MI	ores (situs	
					iopey Vir	730 0.16	man in	1 off	o edina	med year		
OUNTY			TV 15/2 (318)	SCHOOL_	loons.	Courtisan	Sydelised	7 11	zerer les	GRADE_		anther
PARENT NAM	ME	- 51115	- Inivite	to to-rise	1.1.110	I	PHONE N	0	cot cron	ivera is	dinan	7101
OR UARDIAN ADI	DRESS	nanged, o	itered, c	E 80 100 7	(sin rate)	rop. This	CITY	e ini	lone not	Z	IP	Revol
		RECOR	RD OF I	MMUNIZ	ZATION	S (See N	otes On (Other	· Side)		1893	OF.
ose # DTP-DTaP	Polio	Hib	Heb B	PCV7	Vaccines Ty Rotavirus	pe MCV4	HPV	Dose	Hep A	MMR	Varicella	History
DT-Td-Tdap Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	#	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Varicel Diseas Mo/Yi
ar local health	provider o	<u>lauthean</u>	s wd bay	mans ba	Devretive	a ed pau	2.20/1/00	es He	rol set	h between	Back & S	1010/1
ed or retained	dizaba eli	identesti	dent was	ita sili sta	mg the d	ya follon	endar da	2	ter than	al on his	mita job	
3	ragerst o	ne (tribien	tanigog	whosence	30000	facys ale	a terrologic	TOV	Other	Other	Other	Other
5								1	TATCH	sbT Ae1	ergra)	
so I zitisaa	f salsaim	zamum	mensler	nilogram	ad ni si	intercon	si urtiro n	ani.	Lasies	a,	ع إحسوا ها	
the best of my l	moviledge t	he veccines	listed abo	ve were od	ministered :	as indicated	inneracci.	छर्च -स	orelo mois	Office Sta	ımn	
Signature (Medical provider, loca Signature	l health departmer	Title nt official, schoo Title	l official, or chi	ld care provider	Date only)	desio.	ni oldatq ni Resti	309	filki eks	of disease		
Signature (Medical provider, local Signature Signature and 3 at 1)	l health departmen	Title at official, schoo Title Title Title Title	e e f vaccine	ld care provider	Date Date Date Date	te nitial sign	reprise to a	V-10	ficial at a erit mori ur er nas	disean	gaiwwi ngapaw	of ad
Signature (Medical provider, local Signature Signature innes 2 and 3 at LOST OR DEST	re for certi	Title Title Title Title Title CORDS: (I	e f vaccine	es given a	Date Date Date Date Date Date Date	te nitial sign	al provide			alth depar	tment. So	ee note
Signature (Medical provider, loca) Signature Signature sines 2 and 3 as LOST OR DEST I hereby certify t	re for certi	Title Title Title Title Title CORDS: (I	e of vaccine Must be re	es given a	Date Date Date Date Date Date Date Date	te nitial sign by a medic	al provide	obtain	able.	lidogy ans wargozo washiy	rtment. So	ee note
Signature (Medical provider, loca) Signature Signature sines 2 and 3 as LOST OR DEST I hereby certify t	re for certi ROYED RE	Title Title Title Title Title CORDS: (I	e of vaccine Must be re	es given a	Date Date Date Date Date Date Date Date	te nitial sign by a medic	al provide	obtain		lidogy ans wargozo washiy	tment. So	ee note
Signature (Medical provider, loca Signature Signature ines 2 and 3 at LOST OR DEST I hereby certify t Signed: COMPLETE TH	re for certi ROYED RE hat the immu	Title Title Title Title Title CORDS: (I	e f vaccine Must be re ecords of the	es given a	Date Date Date Date Date Date Date Date	te nitial sign by a medic , destroyed	al provide	obtain — M IMI	able. Date:	TION ON	MEDICA	
Signature (Medical provider, local Signature S	re for certi ROYED RE hat the immu Pa (E APPROP G GROUNDS TRAINDIC has a valid m	Title Title Title Title Title Title Title CORDS: (Interpretation researched and the second s	e of vaccine Must be re ecords of the ardian CTION BE MUNIZAT	es given a viewed and his child have	Date only) Date Date Date Date Date Date Date Date	te by a medic destroyed D IS EXEM BEEN REC at this time	al provide I or are und MPT FROI CEIVED S	obtain — M IMI	able. Date: MUNIZAT LD BE EN	TION ON TERED 2	MEDICA ABOVE.	L 02,031
Signature (Medical provider, local Signature S	re for certi ROYED RE hat the immu Pa (E APPROP G GROUNDS TRAINDIC has a valid m	Title Title Title Title Title Title Title CORDS: (Interpretation researched and the second s	e of vaccine Must be re ecords of the ardian CTION BE MUNIZAT	es given a viewed and his child have	Date only) Date Date Date Date Date Date Date Date	te by a medic destroyed D IS EXEM BEEN REC at this time	al provide I or are und MPT FROI CEIVED S	obtain — M IMI	able. Date: MUNIZAT LD BE EN	TION ON TERED 2	MEDICA ABOVE.	L 02,031
Signature (Medical provider, loca Signature Signature Signature LOST OR DEST I hereby certify t Signed: COMPLETE THOR RELIGIOUS MEDICAL CON The above child in this is a periodical periodica	re for certi ROYED RE hat the immu Pa E APPROP G GROUNDS TRAINDIC manent cond the box, indicate	Title CORDS: (I	e of vaccine Must be re ecords of the ardian CTION BE MUNIZATI traindication emporary co (s) and reas	es given a viewed and ais child have ELOW IF TITIONS THE	Date Date Date Date Date Date Date Date	by a medic c, destroyed D IS EXEM BEEN REC	al provide I or are une MPT FROI CEIVED S e.	M IMI	able. Date: MUNIZAT LD BE EM	TION ON ATERED A	MEDICA ABOVE.	L casal
Signature (Medical provider, loca Signature Signature Signature LOST OR DEST I hereby certify t Signed: COMPLETE THOR RELIGIOUS MEDICAL CON The above child I This is a peri	re for certi ROYED RE hat the immu Pa IE APPROP G GROUNDS TRAINDIC has a valid manent cond the box, indicate	Title Title Title Title Title Title Title Title Title CORDS: (Interpretation reserved or Guarantization reserved or Guarantization reserved or Guarantization in Guarantizati	e of vaccine Must be re ecords of the ardian CTION BE MUNIZAT traindication emporary co (s) and reas	es given a viewed and ais child have ELOW IF TITIONS THE	Date Date Date Date Date Date Date Date	by a medic c, destroyed D IS EXEM BEEN REC	al provide I or are une MPT FROI CEIVED S e.	M IMI	able. Date: MUNIZAT LD BE EM	TION ON STERED 2	MEDICA ABOVE.	L casal
Signature (Medical provider, local Signature Signature Signature Signature Signature Signature Signature Signature Signature COMPLETE THOR RELIGIOUS MEDICAL CONTRIBUTION The above child In This is a periodical periodical signature (Medical Signature) periodical signature (Medical Signature) signature (Medical Provider, local Signature) signature (Medical Provider, local Signature) signature (Medical Signature) signature (M	re for certi ROYED RE hat the immu Pa E APPROP G GROUNDS TRAINDIC has a valid manent cond the box, indicate Ph SJECTION: uardian of the	Title Title Title Title Title Title Title Title Title CORDS: (I unization re rent or Gua RIATE SE S. ANY IM ATION: nedical cont ition to ate vaccine nysician or I ne child iden	e of vaccine Must be re ecords of the ardian CTION BE MUNIZAT traindication emporary components of the component	es given a viewed and his child have ELOW IF TITIONS TH. on to being condition to being	Date Date Date Date Date Date Date Date	by a medic destroyed D IS EXEMBLEN REC at this time	al provide l or are une MPT FROI CEIVED S e.	M IMI SHOU	Date: MUNIZAT LD BE EN Date	TION ON OTTERED A	MEDICA ABOVE.	L case

DHMH Form 896 Rev. 3/09 Center for Immunization www.EDCP.org (Immunization)

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).