

|                                    |  |                                 |  |                                 |  |  |  |                      |  |  |  |  |  |
|------------------------------------|--|---------------------------------|--|---------------------------------|--|--|--|----------------------|--|--|--|--|--|
| CHILD'S NAME _____                 |  |                                 |  |                                 |  |  |  |                      |  |  |  |  |  |
| LAST                               |  |                                 |  | FIRST                           |  |  |  | MI                   |  |  |  |  |  |
| SEX: MALE <input type="checkbox"/> |  | FEMALE <input type="checkbox"/> |  | BIRTHDATE _____ / _____ / _____ |  |  |  |                      |  |  |  |  |  |
| COUNTY _____                       |  |                                 |  | SCHOOL _____                    |  |  |  | GRADE _____          |  |  |  |  |  |
| PARENT OR GUARDIAN NAME _____      |  |                                 |  |                                 |  |  |  | PHONE NO. _____      |  |  |  |  |  |
| GUARDIAN ADDRESS _____             |  |                                 |  |                                 |  |  |  | CITY _____ ZIP _____ |  |  |  |  |  |

  

| Dose # | DTP-DTaP-DT<br>Mo/Day/Yr | Polio<br>Mo/Day/Yr | Hib<br>Mo/Day/Yr | Hep B<br>Mo/Day/Yr | PCV<br>Mo/Day/Yr | Rotavirus<br>Mo/Day/Yr | MCV<br>Mo/Day/Yr | HPV<br>Mo/Day/Yr | Hep A<br>Mo/Day/Yr | MMR<br>Mo/Day/Yr  | Varicella<br>Mo/Day/Yr | Varicella<br>Disease<br>Mo / Yr | COVID-19<br>Mo/Day/Yr |
|--------|--------------------------|--------------------|------------------|--------------------|------------------|------------------------|------------------|------------------|--------------------|-------------------|------------------------|---------------------------------|-----------------------|
| 1      | DOSE #1                  | DOSE #1            | DOSE #1          | DOSE #1            | DOSE #1          | DOSE #1                | DOSE #1          | DOSE #1          | DOSE #1            | DOSE #1           | DOSE #1                |                                 | DOSE #1               |
| 2      | DOSE #2                  | DOSE #2            | DOSE #2          | DOSE #2            | DOSE #2          | DOSE #2                | DOSE #2          | DOSE #2          | DOSE #2            | DOSE #2           | DOSE #2                |                                 | DOSE #2               |
| 3      | DOSE #3                  | DOSE #3            | DOSE #3          | DOSE #3            | DOSE #3          | DOSE #3                | DOSE #3          | DOSE #3          | Td<br>Mo/Day/Yr    | Tdap<br>Mo/Day/Yr | MenB<br>Mo/Day/Yr      | Other<br>Mo/Day/Yr              |                       |
| 4      | DOSE #4                  | DOSE #4            | DOSE #4          | DOSE #4            | DOSE #4          |                        |                  |                  |                    |                   |                        |                                 |                       |
| 5      | DOSE #5                  |                    |                  |                    |                  |                        |                  |                  |                    |                   |                        |                                 |                       |

  

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

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: ☐ Permanent condition    OR    ☐ 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 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 MDH 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; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

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 MDH COMAR 10.06.04.03 are available at [www.health.maryland.gov](http://www.health.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.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)



**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

\_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

\_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

\_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

\_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

\_\_\_\_\_

-----

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 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: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

### EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

### INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

**PART I - HEALTH ASSESSMENT**  
**To be completed by parent or guardian**

|                                                                                                                                                                                                                                                                                                          |                               |                             |                                                                                                |                                 |                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------|------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------|
| <b>Child's Name:</b>                                                                                                                                                                                                                                                                                     |                               |                             | <b>Birth date:</b>                                                                             |                                 | <b>Sex</b>                                            |
| <div style="display: flex; justify-content: space-between;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>                                                                                                                                                                             |                               |                             | <div style="display: flex; justify-content: space-between;"> <span>Mo / Day / Yr</span> </div> |                                 | M <input type="checkbox"/> F <input type="checkbox"/> |
| <b>Address:</b>                                                                                                                                                                                                                                                                                          |                               |                             |                                                                                                |                                 |                                                       |
| <div style="display: flex; justify-content: space-between;"> <span>Number</span> <span>Street</span> <span>Apt#</span> <span>City</span> <span>State</span> <span>Zip</span> </div>                                                                                                                      |                               |                             |                                                                                                |                                 |                                                       |
| <b>Parent/Guardian Name(s)</b>                                                                                                                                                                                                                                                                           |                               | <b>Relationship</b>         | <b>Phone Number(s)</b>                                                                         |                                 |                                                       |
|                                                                                                                                                                                                                                                                                                          |                               | W:                          | C:                                                                                             | H:                              |                                                       |
|                                                                                                                                                                                                                                                                                                          |                               | W:                          | C:                                                                                             | H:                              |                                                       |
| <b>Medical Care Provider</b>                                                                                                                                                                                                                                                                             | <b>Health Care Specialist</b> | <b>Dental Care Provider</b> | <b>Health Insurance</b>                                                                        | <b>Last Time Child Seen for</b> |                                                       |
| Name:                                                                                                                                                                                                                                                                                                    | Name:                         | Name:                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | <b>Physical Exam:</b>           |                                                       |
| Address:                                                                                                                                                                                                                                                                                                 | Address:                      | Address:                    | <b>Child Care Scholarship</b>                                                                  | <b>Dental Care:</b>             |                                                       |
| Phone:                                                                                                                                                                                                                                                                                                   | Phone:                        | Phone:                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | <b>Specialist:</b>              |                                                       |
| <b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.                                                                                                                         |                               |                             |                                                                                                |                                 |                                                       |
|                                                                                                                                                                                                                                                                                                          | <b>Yes</b>                    | <b>No</b>                   | <b>Comments (required for any Yes answer)</b>                                                  |                                 |                                                       |
| Allergies                                                                                                                                                                                                                                                                                                | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Asthma or Breathing                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| ADHD                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Autism Spectrum Disorder                                                                                                                                                                                                                                                                                 | <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"/>    |                                                                                                |                                 |                                                       |
| Communication                                                                                                                                                                                                                                                                                            | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Developmental Delay                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Diabetes Mellitus                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Ears or Deafness                                                                                                                                                                                                                                                                                         | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Eyes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Feeding/Special Dietary Needs                                                                                                                                                                                                                                                                            | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Head Injury                                                                                                                                                                                                                                                                                              | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Heart                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Hospitalization (When, Where, Why)                                                                                                                                                                                                                                                                       | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Lead Poisoning/Exposure                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Life Threatening/Anaphylactic 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"/>    |                                                                                                |                                 |                                                       |
| Sensory Impairment                                                                                                                                                                                                                                                                                       | <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"/>    |                                                                                                |                                 |                                                       |
| Vision                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| Other                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/>      | <input type="checkbox"/>    |                                                                                                |                                 |                                                       |
| <b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.                                                                   |                               |                             |                                                                                                |                                 |                                                       |
| <b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan |                               |                             |                                                                                                |                                 |                                                       |
| <b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)<br><input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan                    |                               |                             |                                                                                                |                                 |                                                       |
| 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.                                                                                                                             |                               |                             |                                                                                                |                                 |                                                       |
| <b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>                                                                                                                                                                                      |                               |                             |                                                                                                |                                 |                                                       |
| Printed Name and Signature of Parent/Guardian                                                                                                                                                                                                                                                            |                               |                             |                                                                                                |                                 | Date                                                  |

**PART II - CHILD HEALTH ASSESSMENT**  
To be completed **ONLY** by Health Care Provider

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------|-----------------|
| <b>Child's Name:</b> _____<br><div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                          |                          | <b>Birth Date:</b> _____<br><div style="display: flex; justify-content: space-between; font-size: small;"> <span>Month / Day / Year</span> </div> |                          | <b>Sex</b><br>M <input type="checkbox"/> F <input type="checkbox"/> |                 |
| 1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 2. Does the child receive care from a Health Care Specialist/Consultant?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 3. 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.<br><input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 4. Health Assessment Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| <b>Physical Exam</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>WNL</b>               | <b>ABNL</b>              | <b>Not Evaluated</b>     | <b>Health Area of Concern</b>                                                                                                                     | <b>NO</b>                | <b>YES</b>                                                          | <b>DESCRIBE</b> |
| Head                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Eyes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Ears/Nose/Throat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Attention Deficit/Hyperactivity                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Dental/Mouth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autism Spectrum Disorder                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorder                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Cardiac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Gastrointestinal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema/Skin issues                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Genitourinary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feeding Device/Tube                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Musculoskeletal/orthopedic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lead Exposure/Elevated Lead                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Neurological                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mobility Device                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Endocrine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nutrition/Modified Diet                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical illness/impairment                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Psychosocial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Vision                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Epilepsy                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Speech/Language                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensory Impairment                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Hematology                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Developmental Disorder                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/>                                            |                 |
| Developmental Milestones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other:                                                                                                                                            |                          |                                                                     |                 |
| <b>REMARKS:</b> (Please explain any abnormal findings.)<br><div style="height: 40px;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 5. Measurements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          | Date                     |                          | Results/Remarks                                                                                                                                   |                          |                                                                     |                 |
| Tuberculosis Screening/Test, if indicated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| Blood Pressure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| Height                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| Weight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| BMI % tile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| Developmental Screening                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 6. Is the child on medication?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis:<br><b>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).</b><br><a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 7. Should there be any restriction of physical activity in child care?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 8. Are there any dietary restrictions?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 9. <b>RECORD OF IMMUNIZATIONS</b> – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 896.)                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |
| 10. <b>RECORD OF LEAD TESTING</b> - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 4620)<br><br>Under Maryland law, all children younger than 6 years old who are enrolled in child care 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. |                          |                          |                          |                                                                                                                                                   |                          |                                                                     |                 |

Additional Comments: \_\_\_\_\_

|                                            |               |                                 |       |
|--------------------------------------------|---------------|---------------------------------|-------|
| Health Care Provider Name (Type or Print): | Phone Number: | Health Care Provider Signature: | Date: |
|                                            |               |                                 |       |



## Screen Time Policy

Because we care about the health and well-being of the children in our care, we follow the American Academy of Pediatrics' Recommendations on Screen Time:

- Children under 2 should have no screen time.
- Children age 2 and over should watch less than 30 minutes per week at child care, and less than 2 hours per day total.

**Somos Early Learning program** understands that TV and other electronic media can get in the way of exploring, playing, and interacting with others, which encourages learning and healthy physical and social development. Therefore, we will restrict screen time by:

- Allowing a maximum of 30 minutes' total per week of educational and age appropriate screen time (television, video, and DVD).
- Not allowing any screen time during meals and snacks.
- Having zero screen time (TV, video, and computer) for children under the age of two.

Child's Name \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## Walking Permission Slip

Dear parents,

On occasion, we may take a walk to the neighborhood park, plan nature walks, or walk around just for exercise. These walking trips are not always planned. By signing this permission slip, you are giving Somos Early Learning Preschool and staff members permission to take your child on a walk. If you choose not to have your child participate in this activity, please indicate your wish below.

- ☐ I give my child permission to participate in walking field trips.
- ☐ My child cannot participate in walking field trips for this reason:

\_\_\_\_\_

Student's Name (s): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

# MARYLAND DEPARTMENT OF HEALTH 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 |
|-----------|------------------------------|-----------------|----------|
|           | Make a selection:            |                 |          |
|           | Make a selection:            |                 |          |
|           | Make a selection:            |                 |          |

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