

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____	_____	_____	_____	_____
_____	Last	First	Middle	Birth Date
Name of Parent or Guardian _____				_____
Home Address _____				Relationship
City _____	State _____	Zip Code _____		
Check Best Telephone Number to Reach You:				
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____	<input type="checkbox"/> Cell #: _____		

Dear Parent/Guardian:

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

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

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

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

City/Town _____ State _____ Zip Code _____

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

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

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

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

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

a. Vision problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
b. Hearing problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
c. Speech or language problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
d. Other physical illness or impairment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
e. Mental, emotional or behavior problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
f. Developmental delays	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
g. Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO
 If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.
 YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO
 If YES, please specify: _____

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

8. Does this child's physical activity need to be restricted? YES NO
 If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO
 If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO
 If YES, please specify type: _____

Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Dose #	Vaccine Types											
	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

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

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

Signature of Health Practitioner _____ Date _____ Phone Number _____

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

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required. The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

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