MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

**Child's Name**__________________________________ ______________
**Last** **First** **Middle** **Birth Date**

**Name of Parent or Guardian** ____________________________ ______________
**Relationship**

**Home Address** ________________________________________

**City**____________________ **State** ________ **Zip Code** ____________

**Check Best Telephone Number to Reach You:**

☐ **Home #:** ____________ ☐ **Work #:** ____________ ☐ **Cell #:** ____________

Dear Parent/Guardian:

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

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

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

**PLEASE RETURN THIS COMPLETED FORM TO:**

**Name of Child Care Facility:**________________________________

**Address:**________________________________________

________________________________________________
**City/Town** **State** **Zip Code**

## PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

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

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

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

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

__________________________________ __________________

**Signature of Parent/Guardian** **Date**

## PART II: MEDICAL INFORMATION

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

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

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

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___
3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)
   - a. Vision problem ☐YES ☐ NO ______________________________
   - b. Hearing problem ☐YES ☐ NO ______________________________
   - c. Speech or language problem ☐YES ☐ NO ______________________________
   - d. Other physical illness or impairment ☐YES ☐ NO ______________________________
   - e. Mental, emotional or behavior problems ☐YES ☐ NO ______________________________
   - f. Developmental delays ☐YES ☐ NO ______________________________
   - g. Allergies ☐YES ☐ NO ______________________________

   Significant physical findings, comments and recommendations: ______________________________
4. This child has a health condition which may require care or emergency action while at child care. ☐YES ☐ NO

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

   ______________________________

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

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

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

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

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

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

    If YES, please specify type: ______________________________

    Special instructions for use: ______________________________

## RECORD OF IMMUNIZATIONS

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

## PART II: MEDICAL INFORMATION (CONTINUED)

**Child's Name** ________________________________________

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

______________________________________________________________________________________________

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

____________________________________ ______________ ________________________________________
**Signature of Health Practitioner** **Date** **Phone Number**

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

## CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

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

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