# **Child Health Form**

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			кеганопѕпір
City		_StateZip	p Code
Check Best Telephone Number to	Reach You:		
☐ Home #:		□ Ce	II #:
Dear Parent/Guardian:			
health check-up should include free of communicable disease. This form requests health and Health Practitioner in evaluating	e physical examination individual needs infor ng your child, and me m your child's Health	m and immunizations whi rmation from you (Part I) dical information, lead so	a doctor at regular intervals. The ich are necessary to keep your child, which will be helpful to the creening/testing and proof of agehis information must be completed
six years of age have approp	riate screening for le he State (see page 4)	ad poisoning. Children designated as at-risk fo	ations and that children less than who reside (or have ever r childhood lead poisoning <u>must</u>
PLEASE RETURN THIS COMPI	LETED 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:

To be completed by Prike Private Strain Stra		
IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILITHE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS Explanation, if needed, can be given in the space provided for "REMARKS".		
. Are you concerned about your child's general health (eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?		
. 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?		
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?		
Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)?		
Does your child have any allergies? If YES, please state what kind of allergies:		
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?		
Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	r	
Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?		
EMARKS (Provide further explanation for all "YES" answers):		
GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I USONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. I ATTEST THAT INF THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.		) ON
Signature of Parent/Guardian Date		

### PART II: MEDICAL INFORMATION

То	be completed by a <b>HEALTH PRACTITIO</b>	NER		CHILD'S NAM	E:	
1.	Date of this child's most recent tuberculin te	st:/	_/ Result: _	Positive _	Negative	
Un	der Maryland law, a child under the age of six i	must have a	appropriate screen	ing/testing for le	ad poisoning. See pa	ge 4.
2.	Date of this child's lead screening:/	_/	Blood lead test	dates: Test 1:	// Tes	t 2:/
3.	This child has the following which may sign	ificantly a	ffect his/her child	care experience	: (COMM	ENTS)
	a. Vision problem	$\square$ YES	□ NO			
	b. Hearing problem	$\square$ YES	□ NO			
	c. Speech or language problem	$\square$ YES	□ NO			
	d. Other physical illness or impairment	$\square$ YES	□ NO			
	e. Mental, emotional or behavior problems	$\square$ YES	□ NO			
	f. Developmental delays	$\square$ YES	□ NO			
	g. Allergies	$\square$ YES	□ NO			
	Significant physical findings, comments and	d recomme	endations:			
4.	This child has a health condition which may	require ca	re or emergency a	ction while at c	hild care. □YES	□ NO
	If YES, please specify (e.g., seizures, bee st	ing allergy	, diabetes, etc.):			
	, p y (,	<i>8</i> · · · <i>8</i>	_			
	Recommendations:					
5.	This child has or is a known carrier of a comm	unicable di	sease which should	d prevent his/her	admission to a child	care facility or school.
	□YES □ NO If YES, please specif			_		•
6.	6. This child requires a modified diet and/or special feeding procedures. □YES □ NO					
	If YES, please specify:		- 1			
7.	If this child cannot fully participate in all area					to suit his/her needs?
<i>,</i> .	if any child cannot rany participate in an area	s or the em	ia care program, w	nat areas snould	oc infinited of differed	to suit mayner needs:
8.	Does this child's physical activity need to be	e restricted	?		□YES	□NO
٠.	If YES, please specify:				_ 120	_ 110
0	Does this child require any specialized treat				DVEC	□ NO
9.	1 7 1				□YES	□ NO
	If YES, please specify:					
10.	Does this child require any adaptive equipr				□YES	□ NO
	If YES, please specify type:					
	Special instructions for use:					

## **RECORD OF IMMUNIZATIONS**

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

#### PART II: MEDICAL INFORMATION (CONTINUED)

	Child's Name					
		ication to being immunized at this time. This is a $\Box$ permanent $\Box$ temporary is:				
HEALTH PRACTITIONER'S STATEMENT: conducted a physical examination of the above-nar		ge, the vaccines listed above were administered as indicated. I he 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 Physici	ian, Certified Nurse Practitio	oner, 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 1<sup>st</sup> test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1<sup>st</sup> and 2<sup>nd</sup> 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 1<sup>st</sup> test is done after 24 months of age, one test is required. The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS	Baltimore (cont)	Carroll	Frederick(cont)	Montgomery	<b>Prince</b>	St. Mary's
BY	21210	21155	21783	20783	George's(cont)	20606
ZIP CODE	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	<b>Charles</b>	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
<b>Baltimore</b>	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	<b>Baltimore City</b>	21704	<b>Howard</b>	20737	21644	Worcester
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	<u>Calvert</u>	21719	<u>Kent</u>	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				