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 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 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 | 20782 | 20606 |
| | 21212 | 21757 | 21787 | 20787 | 20783 | 20626 |
| | 21215 | 21776 | 21791 | 20812 | 20784 | 20628 |
| Allegany | 21219 | 21787 | 21798 | 20815 | 20785 | 20674 |
| ALL | 21220 | 21791 | | 20816 | 20787 | 20687 |
| | 21221 | | Garrett | 20818 | 20788 | |
| Anne Arundel | 21222 | Cecil | ALL | 20838 | 20790 | Talbot |
| 20711 | 21224 | 21913 | | 20842 | 20791 | 21612 |
| 20714 | 21227 | | Harford | 20868 | 20792 | 21654 |
| 20764 | 21228 | Charles | 21001 | 20877 | 20799 | 21657 |
| 20779 | 21229 | 20640 | 21010 | 20901 | 20912 | 21665 |
| 21060 | 21234 | 20658 | 21034 | 20910 | 20913 | 21671 |
| 21061 | 21236 | 20662 | 21040 | 20912 | | 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 | | | | |

# EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

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Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address *(If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address *(If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

**ANNUAL UPDATES** _____ _____ _____ _____
*(Initials/Date)* *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

**INSTRUCTIONS TO PARENT:**

(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

## ALL ABOUT: _____
Child's First Name or Nickname

Child's Name: _____ Birthdate: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Address: _____ Zip Code: _____

Provider/Center: _____ Phone: _____

Address: _____ Zip Code: _____

**The information contained herein is for CONFIDENTIAL USE ONLY.**

### THINGS MY CHILD DOES WELL

### WHAT MY CHILD LIKES AND DISLIKES

### THINGS I AM WORKING ON WITH MY CHILD

### MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

| MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES |
| --- |
| |
| MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES |
| |
| THINGS MY CHILD MIGHT NEED HELP WITH |
| |
| WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME?<br>(For the use of the Child Care Facility when needed.) |
| |

This information is intended for use by the child care provider, developed in cooperation with the parents. THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.

Signatures:

Parent/Guardian: _____ Date: _____

Provider: _____ Date: _____

Updates:

Parent/Guardian: _____ Date: _____ Parent/Guardian: _____ Date: _____

Provider: _____ Provider: _____