

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

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