MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

HEALTH INVENTORY ADDENDUM

CHILD'S PERSONAL RECORD FOR CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

Under Maryland law, a child under six years of age who is admitted to child care must have appropriate screening for lead poisoning. Parents or guardians must submit evidence of this screening to the child care provider within 30 days of admission to care.

To be completed by a HEALTH PRACTITIONER

_______________________________________ _____________________
Child's Name Birthdate

has received appropriate screening and/or testing for lead poisoning.

_______________________________________ _____________________
Signature of Health Practitioner Date

_______________________________________ _____________________
Street Address Phone

____
City State Zip

_______________________________________ _____________________
Name of Parent or Guardian Date

_______________________________________ _____________________
Street Address Phone

____
City State Zip

____
PLEASE RETURN THIS COMPLETED FORM TO:

Name of ____
Child Care Center, Family Child Care Home, School

____
Street Address

____
City State Zip

ATTENTION: ____________________________________

(THIS FORM MAY BE DUPLICATED AS NEEDED)

PART I -- STUDENT HEALTH HISTORY
--To be completed by parent/guardian --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	School	Grade
Address (Number, Street, City, State, Zip)		Phone No.	
Parent or Legal Guardian Names			

Where do you usually take your child for medical care? Phone No.:

Name: Address:

When was the last time your child had a physical exam?

Month: Year:

Where do you usually take your child for dental? Phone No.:

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have a history of or any problems with the following. Please check yes or no.

	Yes	**No**	**Comments**
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problem or Deafness			
Speech Problem			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Allergies, (Food, Insects, Drugs, etc.)			
Behavior or Emotional Problem			
	Yes	**No**	**Comments**
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			

Does your child take any medication(s)? ☐ Yes ☐ No

Name of Medication(s)____

Parent or Legal Guardian Signature ______________________________ Date ____________

PART II -- STUDENT HEALTH ASSESSMENT / PHYSICAL EXAMINATION

--To be completed by physician or certified nurse practitioner --

Student Name (Last, First, Middle	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

Address (Number, Street, City, State, Zip)	Phone No.

1. Does this child have a health condition which may require EMERGENCY ACTION while he/she is at school: (e.g., seizure, insect sting, asthma, allergy, bleeding problem, diabetes, heart problem?) If yes, please DESCRIBE:
   ☐ No ☐ Yes ____
   ____

2. Is the student on long-term medication? If yes, please DESCRIBE
   ☐ No ☐ Yes ____
   ____
   (A Medication administration form must be completed for in-school administration.

3. Is this child on long-term technology assistance?
   ☐ No ☐ Yes ____
   (Please note specifics) ____

4. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a √ in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision …………………..	______	______	______	Adjustment …………	______	______	______
Hearing …………………	______	______	______	Nutrition …………….	______	______	______
Speech/Language ………	______	______	______	Physical Illness/impairment	______	______	______
Development …………..	______	______	______	Immunodeficiency ……….	______	______	______
Attention Deficit/Hyperactivity	______	______	______	Lead Poisoning …………..	______	______	______
Scoliosis	______	______	______	Other …………………….	______	______	______

REMARKS: (Please explain any "yes"; include recommendation for referral and treatment.)

____

____

____

5. Should there be any restriction on physical activity at school? If so, specify nature and duration of restriction.
   ☐ No ☐ Yes ____
   ____

6. Tuberculin Test: Results Type Date of Last Test duration of restriction.
   ☐ Positive ☐ Negative

Blood Pressure Height Weight Date Taken

If you would like to discuss this student's health with school or school health personnel, check title below

☐ Nurse assigned to school ☐ Teacher(s) ☐ Counselor ☐ Principal ☐ School Health Physician ☐ Other

(Student Name) ______________________________ has had a complete physical examination and has

☐ no evident problem that may affect learning OR ☐ problems noted above.

Physician/Certified Nurse Practitioner (Type or Print)	Phone No.	Physician Certified Nurse Practitioner (Signature)	Date

-- Additional Comments on Reverse Side --