

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____			_____
_____	_____	_____	_____
Name of Parent or Guardian _____			_____
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".

	<b>YES</b>	<b>NO</b>
1. Are you concerned about your child's general health ( <i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i> )?	_____	_____
2. Does your child have any eye problems ( <i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i> )?  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 ( <i>frequent earaches, difficulty hearing, etc.</i> )?  Date of last hearing evaluation ____/____/____      Doctor's Name: _____  Results: _____  Does your child use a hearing aid? _____	_____  _____  _____	_____  _____  _____
4. Does your child have any speech problems ( <i>difficulty having speech understood, stammering, delayed speech development, etc.</i> )?	_____	_____
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 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	<u>Baltimore (cont)</u>	<u>Carroll</u>	<u>Frederick(cont)</u>	<u>Montgomery</u>	<u>Prince George's(cont)</u>	<u>St. Mary's</u>
<b>BY</b>	21210	21155	21783	20783	20782	20606
<b>ZIP CODE</b>	21212	21757	21787	20787	20783	20626
	21215	21776	21791	20812	20784	20628
<u>Allegany</u>	21219	21787	21798	20815	20785	20674
ALL	21220	21791		20816	20787	20687
	21221		<u>Garrett</u>	20818	20788	
<u>Anne Arundel</u>	21222	<u>Cecil</u>	ALL	20838	20789	<u>Talbot</u>
20711	21224	21913		20842	20791	21612
20714	21227		<u>Harford</u>	20868	20792	21654
20764	21228	<u>Charles</u>	21001	20877	20799	21657
20779	21229	20640	21010	20901	20912	21665
21060	21234	20658	21034	20910	20913	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237		21078	20913		21676
21226	21239	<u>Dorchester</u>	21082		<u>Queen Anne's</u>	
21402	21244	ALL	21085	<u>Prince George's</u>	21607	<u>Washington</u>
	21250		21130	20703	21617	ALL
<u>Baltimore</u>	21251	<u>Frederick</u>	21111	20710	21620	
21027	21282	20842	21160	20712	21623	<u>Wicomico</u>
21052	21286	21701	21161	20722	21628	ALL
21071		21703		20731	21640	
21082		21704	<u>Howard</u>	20737	21644	<u>Worcester</u>
21085	<u>Baltimore City</u>	21716	20763	20738	21649	ALL
21093	ALL	21718		20740	21651	
21111		21719	<u>Kent</u>	20741	21657	
21133	<u>Calvert</u>	21727	21610	20742	21668	
21155	20615	21757	21620	20743	21670	
21161	20714	21758	21645	20746		
21204		21762	21650	20748	<u>Somerset</u>	
21206	<u>Caroline</u>	21769	21651	20752	ALL	
21207	ALL	21776	21661	20770		
21208		21778	21667	20781		
21209		21780				