MARYLAND STATE DEPARTMENT OF EDUCATION Office of Child Care

HEALTH INVENTORY

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

Child's Name:	First	Middle	Birth Date:			
Name of Parent/Guardian:			Relationship:			
Home Address:Street Home Telephone:			State	Zip Code		
Dear Parent/Guardian: Every child should have medical and doctor and dentist at regular intervals. necessary to keep your child free of co Maryland law requires you to submit p (DHMH 896) to the center, home, or so This form requests health information complete will be helpful to the Health	Health check-ups shommunicable disease. broof of age-appropria chool. This must be from you (Part I) and	ould include physate immunizations done before your from your child'	sical examination and impose on the Maryland Immurchild can be admitted. s Health Practitioner (Particular of the second	munizations which are		
PLEASE RETURN THIS COMPLETED FORM TO: Name of: Child Care Center, Family Child Care Home, School						
Address:		Street				
City		State	Zip	Code		

PART I: CHILD'S INFORMATION

To be completed by PARENT/GUARDIAN

IM	PORTANT:	COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THE TO THE HEALTH PRACTITIONER.	S FORN	M WITH YOU	
		PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE needed, can be given in the space provided for "REMARKS".	RIGHT. YES	Explanation, if NO	
1.	Are you conc bowel/bladde				
2.	Does your chi	ild have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes)?			
	Date of last e	eye examination:/ Doctor's Name:			
	Results:				
	Does your ch	ild wear glasses?			
	Contact lense	es?			
3.	Does your ch	Ooes your child have any ear or hearing problems (frequent earaches, difficulty hearing, etc.)?			
	Date of last h	nearing evaluation/ Doctor's Name:			
	Results:				
	Does your ch	aild use a hearing aid?			
4.	Does your ch development,	aild have any speech problems (difficulty having speech understood, stammering, delayed speech etc.)?			
5.	Does your cl	hild have any allergies? If YES, please state what kind of allergies:			
6.	Does your cl under "Rema	hild have any other specific illness, disability or other limiting condition? If YES, give details arks".			
	(a) Does thi	s condition require any special health care in the child care facility or school?			
		r child received evaluation, which could help the child care provider or teacher in meeting his/her reducation needs? If YES, give details under "Remarks".			
	(c) Does you	ur child require any adaptive equipment?			
7. RE	school teach	e concerns about your child's behavior or emotional well-being which the child care provider or er should know about? If YES, give details under "Remarks". **rify any "YES" answers):			
		PARENT'S STATEMENT – ALL MUST SIGN AND DATE BELOW	_ — — -		
IG	IVE MY DEDI	MISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTA	ND IT I	S FOR	
CO	NFIDENTIAL	USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS IN CHILD CARE OR SCHOOL			
	ase fill in, if child				
ı gı	ve my permissior	n to School to releaseName of Child			
Hea	lth information t	O		·	
I A	TTEST THAT IN	FORMATION 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: Date of this child's most recent tuberculin test: ____/ ____/ Result: Positive Negative This child has the following which may significantly affect his/her child care or educational experience: **COMMENTS** ☐ YES a. Vision problem □ NO _ □ NO _____ b. Hearing problem ☐ YES c. Speech or language problem ☐ YES d. Other physical illness or impairment ☐ YES Mental, emotional or behavior problems ☐ YES \square NO f. Developmental delays ☐ YES ☐ YES g. Allergies Significant physical findings, comments and recommendations: This child has a health condition which may require care or emergency action while at child care/school. _____YES Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): Recommendations: ___ 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: _____ This child requires a modified diet and/or special feeding procedures. _____ YES _____ NO If YES, please specify: ____ ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT: 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? 7. Does this child's physical activity need to be restricted? ____ YES ____ NO If YES, please specify: ____YES ___ NO Does this child require any specialized treatment? If YES, please specify: _____ _____ YES _____ NO Does this child require any adaptive equipment (braces, crutches, etc.)? If YES, please specify type: Special instructions for use: HEALTH PRACTITIONER'S STATEMENT I conducted a physical examination of the above-named child on ______and find that he/she IS / IS NOT medically cleared to attend child care or school. (circle correct response) Telephone Number Name of Health Practitioner (Please Print) Signature of Health Practitioner Date

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OCC 1215 (Revised 1/06) - All previous editions are obsolete

PART III – ADDITIONAL COMMENTS

This page is to be used by child care personnel to record signs of illness or accidents observed by the staff and to record when the parent was notified.

It may be used to record reasons for absences and other information related to the child's health status.

Written recommendations by health practitioner or parent following absences may be attached to this record.

DATE	RECORDER	DETAILS
DAIL	KECOKDEK	DETAILS