Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered, or approved child care or nursery school:

- A physical examination by a health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).

- Evidence of Immunizations. The immunization certification form (MDH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms
  Select MDH 896.

- Evidence of Blood-Lead Testing for children younger than 6 years old. The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms
  Select MDH 4620.

- Medication Administration Authorization Forms. If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

EXEMPTIONS

Exemptions from a physical examination, Immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from Immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child’s parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child’s physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or Immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: https://health.maryland.gov/Pages/Home.aspx#

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program
# PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

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<th>Child's Name:</th>
<th>Birth date:</th>
<th>Sex</th>
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<th>Dental Care Provider</th>
<th>Health Insurance</th>
<th>Last Time Child Seen for Physical Exam:</th>
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### ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

- **Allergies**
- **Asthma or Breathing**
- **ADHD**
- **Autism Spectrum Disorder**
- **Behavioral or Emotional**
- **Birth Defect(s)**
- **Bladder**
- **Bleeding**
- **Bowel(s)**
- **Cerebral Palsy**
- **Communication**
- **Developmental Delay**
- **Diabetes Mellitus**
- **Ears or Deafness**
- **Eyes**
- **Feeding/Special Dietary Needs**
- **Head Injury**
- **Heart**
- **Hospitalization (When, Where, Why)**
- **Lead Poisoning/Exposure**
- **Life Threatening/Anaphylactic Reactions**
- **Limits on Physical Activity**
- **Meningitis**
- **Mobility-Assistive Devices if any**
- **Prematurity**
- **Seizures**
- **Sensory Impairment**
- **Sickle Cell Disease**
- **Speech/Language**
- **Surgery**
- **Vision**
- **Other**

### Questions

- Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?
  - [ ] No  [ ] Yes, if yes, attach the appropriate OCC 1216 form.

- Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy/Counseling etc.)
  - [ ] No  [ ] Yes, if yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

- Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)
  - [ ] No  [ ] Yes, if yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

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.

Printed Name and Signature of Parent/Guardian: ____________________________ Date: ________________
### PART II - CHILD HEALTH ASSESSMENT

To be completed ONLY by Health Care Provider

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<th>Child's Name:</th>
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<th>Birth Date:</th>
<th>Month / Day / Year</th>
<th>Sex</th>
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1. **Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?**
   - [ ] No
   - [x] Yes, describe:

2. **Does the child receive care from a Health Care Specialist/Consultant?**
   - [ ] No
   - [ ] Yes, describe:

3. **Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care?**
   - (e.g. seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
   - [ ] No
   - [ ] Yes, describe:

4. **Health Assessment Findings**

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5. **Measurements**

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<th>Test Type</th>
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<th>Results/Remarks</th>
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<td>Developmental Screening</td>
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6. **Is the child on medication?**
   - [ ] No
   - [ ] Yes, indicate medication and diagnosis:
   - [ ] OCC 1216 Medication Authorization Form must be completed to administer medication in child care.
   - [ ] https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. **Should there be any restriction of physical activity in child care?**
   - [ ] No
   - [ ] Yes, specify nature and duration of restriction:

8. **Are there any dietary restrictions?**
   - [ ] No
   - [ ] Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS - MDH 896 or other official Immunization document (e.g. military Immunization record of Immunizations) is required to be completed by a health care provider or a computer generated Immunization record must be provided. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)**

10. **RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620)**

Under Maryland law, all children younger than 6 years old who are enrolled in child care 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.

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**Additional Comments:**

- Health Care Provider Name (Type or Print): ____________________________
- Phone Number: ____________________________
- Health Care Provider Signature: ____________________________
- Date: ____________________________

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OCC 1215 Health Inventory - Revised February 2023 - All previous editions are obsolete. Page 2 of 3
MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. BOX A is to be completed by the parent or guardian. BOX B, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). BOX C should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. BOX D is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A - Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME ________________________________

LAST FIRST MIDDLE

CHILD'S ADDRESS

STREET ADDRESS (with Apartment Number) __________________

CITY __________________ STATE _______________

ZIP __________________

SEX: ☐ Male ☐ Female

BIRTHDATE __________________

PHONE __________________

BOX B - For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ☐ YES ☐ NO

Has this child ever lived in one of the areas listed on the back of this form? ☐ YES ☐ NO

Does this child have any known risks for lead exposure (see questions on reverse of form and talk with your child's health care provider if you are unsure)? ☐ YES ☐ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): __________________________ Signature: __________________________ Date: __________________________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C - Documentation and Certification of Lead Test Results by Health Care Provider

<table>
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<tr>
<th>Test Date</th>
<th>Type (V=venous, C=capillary)</th>
<th>Result (mcg/dL)</th>
<th>Comments</th>
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<td>Make a selection:</td>
<td>Make a selection:</td>
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Comments:

Person completing form: ☐ Health Care Provider/Designee OR ☐ School Health Professional/Designee

Provider Name: __________________________ Signature: __________________________

Date: __________________________ Phone: __________________________

Office Address: __________________________

BOX D - Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): __________________________ Signature: __________________________ Date: __________________________

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This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ☐ YES ☐ NO

Provider Name: __________________________ Signature: __________________________

Date: __________________________ Phone: __________________________

Office Address: __________________________

MDH FORM 4620 REVISED 4/2020 REPLACES ALL PREVIOUS VERSIONS
HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child’s primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child’s school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

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Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 “at risk” zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

MDH Form 4620 REVISED 4/2020 REPLACES ALL PREVIOUS VERSIONS
Maryland Department of Health Immunization Certificate

Children's Name: ___________________________ Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Sex: Male □ Female □

Birthdate: ___/___/___

County: ___________________________ School: ___________________________ Grade: ___________________________

Parent Name: ___________________________ Phone No.: ___________________________

Guardian Address: ___________________________ City: ___________________________ Zip: ___________________________

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To the best of my knowledge, the vaccines listed above were administered as indicated.

1. ___________________________ ___________________________ ___________________________
   Signature Title Date
   (Medical provider, local health department official, school official, or child care provider only)

2. ___________________________ ___________________________ ___________________________
   Signature Title Date

3. ___________________________ ___________________________ ___________________________
   Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Complete the appropriate section below if the child is exempt from vaccination on medical or religious grounds. Any vaccination(s) that have been received should be entered above.

Medical Contraindication:

Please check the appropriate box to describe the medical contraindication.

This is a: □ Permanent condition OR □ Temporary condition until ___/___/___ Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication.

Signed: ___________________________ Medical Provider/LHD Official Date ___________________________

Religious Objection:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: ___________________________ Date: ___________________________

MDH Form 896 (formerly DSMH 896)
Rev. 5/21

Center for Immunization
www.health.maryland.gov/immm