Maryland Schools
Record of
Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** *A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement.* (http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** *A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at: http://www.edcp.org/pdf/DHMH896new.pdf.*

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** *The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* http://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a families religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://www.marylandpublicschools.org/NR/rdonlyres/8D9E900E-13A9-4700-9AA8-5529C5F4C749/3341/medicationform404.pdf. **If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene — Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

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

Parent/Guardian Names

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

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?

No Yes Name(s) of Medications: ______________________________

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No Yes Treatment ______________________________

Does your child require any special procedures? (catheterization, etc.)

No Yes

Parent/Guardian Signature ______________________________ Date: ______________

PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes ____________________

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes ____________________

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No Yes
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ____________________

7. **Screenings**	**Results**	**Date Taken**
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) ____ has had a complete physical examination and has

no evident problem that may affect learning or full school participation   problems noted above

____

Additional Comments:

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

How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.EDCP.org (Immunization).

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ______/______/______

COUNTY ____________________ SCHOOL ______________________ GRADE ______

PARENT OR GUARDIAN NAME ______________________ PHONE NO. ______________________

ADDRESS ______________________ CITY ______________ ZIP ______

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease
1									1				Mo/Yr
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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.

Clinic / Office Name
Office Address/ Phone Number

LOST OR DESTROYED RECORDS: **(Must be reviewed and approved by a medical provider or the local health department. See notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: ______________________________ Date: ______________
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ______/______/______

Check appropriate box, indicate vaccine(s) and reasons: ______________________________

Signed: ______________________________ Date ______________
Medical Provider / LHD Official

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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: ______________________________ Date: ______________

Baltimore County Public Schools
Towson, Maryland

Baltimore County Department of Health
Baltimore, Maryland

New Student Health History

Last Name: ____________ First Name: ____________ Grade/Teacher: ________ Gender: ___

Last school your child attended? ______________________ DOB: ____________

Where do you usually take your child for routine medical care?

Name: ______________________ Phone Number: ____________

Does your child take any medication? ☐ Yes ☐ No If yes, list medications:

____

Does your child require any special health treatments or procedures (e.g. tube feeding or catheterization)? ☐ Yes ☐ No

If yes, describe: ____

____

Where do you usually take your child for routine dental care?

Name: ______________________ Phone Number: ____________

To the best of your knowledge, has your child had any of the following?

	Yes	No	If yes, describe:
Prematurity			
Birth defect			
Immunity problems			
Bleeding problems			
Lead poisoning			
Sickle Cell Disease			
Diabetes			
Anaphylaxis			
Seasonal allergies			
Food Allergies			
Behavior/emotional problems like ADHD, depression			
Concussion or traumatic brain injury			
Migraines			
Learning problems/disabilities			
Seizures			
Speech problems			
Ear or hearing problems			
Eye or vision problems			
Dental problems			
Asthma or breathing problems			
Heart problems			
Stomach problems			
Bowel problems			
Bladder problems			
Musculoskeletal problem (including cerebral palsy)			
Limited physical activity			
Other:			

Hospitalization: (please list all) Date(s)	Reason(s)
Surgery: (please list all) Dates(s)	Reason(s)

Parent Signature: ______________________ Telephone: ____________ Date: ________

Parent Address: ____

BEBCO 5443-13

Parent Health Form Checklist

Required to start Kindergarten or Grade 1
(Due to school nurse by the first day of school)

______ Maryland Department of Health and Mental Hygiene Immunization Certificate (Must have all required immunizations up to date and documented)

______ Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (Must show proof of lead testing or sign the testing exemption line)

______ Sparks Elementary School Health Registration

Required within 6 months after entering the school system

______ Maryland Schools Record of Physical Examination (Must be completed and signed by physician)

______ School Dental Health Record

Required for your child to receive medication in school

______ Consent for Administration of Approved Discretionary Medications

______ Parent's Request to Adminster Medication in School (Required for all prescription medications and all medications not listed on the Discretionary Medication Form)

BALTIMORE COUNTY PUBLIC SCHOOLS

Joe A. Hairston, Superintendent 6901 Charles Street Towson, Maryland 21204-3711

Dear Parents/Guardians:

Lead poisoning is a significant environmental health threat to young children. Exposure to lead can cause developmental delays, learning disabilities, or behavioral disturbances.

In 2000, the legislature enacted a law, which targets areas in the state that are considered at-risk for childhood lead poisoning. Children entering our schools for the first time in pre-kindergarten, kindergarten, and first grade must have documentation from their health care provider certifying the dates that blood lead tests were done. (Pre-kindergarten means any public school program prior to kindergarten in which your child may be enrolled.) To comply with this new law, this is what parents/guardians must do:

- Have your health care provider provide the dates your child had blood tests for lead poisoning on the attached form if your child currently lives or has lived in any of the zip codes identified on the back of the form, or

- Certify that your child does not live, and has never lived, in the zip codes identified on the back of the attached form by signing the attached form.

If your child has never had a blood lead test and needs one, please see your school nurse who will be able to assist you in obtaining the required test. If you have any questions, please contact your school nurse or contact the Office of Health Services at 410-887-6368.

Thank you for your cooperation in complying with this State requirement.

Sincerely,

Debbie Somerville, RN, MPH
Coordinator
Office of Health Services

BEBCO 3661-07

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

CHILD'S NAME ______________________ / ______________ / ______________
LAST FIRST MIDDLE

CHILD'S ADDRESS ______________________ / ______________ / __________ / __________
ADDRESS CITY STATE ZIP

SEX: ☐ MALE ☐ FEMALE BIRTHDATE ______ / ______ / ______

COUNTY ______________ SCHOOL ______________________ GRADE ______

PARENT OR GUARDIAN ______________ / ______________ / ______________ / ______________
LAST FIRST MIDDLE PHONE

______________________ / ______________ / __________ / __________
ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003, the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

RECORD OF BLOOD LEAD TESTING

Test #1. __________ **Test # 2.** __________ Comments: ______________________
Date Date

Signature ______________________________________ / __________
Health Care Provider or Designee OR School Health Professional or Designee Date

RECORD OF BLOOD LEAD TESTING EXEMPTION

I, ______________________ certify that my child does not **AND** has never resided in an at-risk area.
Parent or Guardian (Print)

Signature ______________________________ / __________
Parent or Guardian Date

COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed ______________________ / __________
Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed ______________________ / __________
Health Care Provider Date

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) 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. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237

Baltimore Co. (Cont.)
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727

Frederick . (Cont)
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787

Montgomery (Cont)
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

BALTIMORE COUNTY PUBLIC SCHOOLS
TOWSON, MD 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
BALTIMORE, MD 21212

School Dental Health Record

Name of Student: ______________________________ Age: ______

Name of School: ______________________________ Grade: ______

All students can achieve a healthy mouth, provided they practice protective health habits from childhood and have the opportunity to benefit from present-day knowledge of dental disease prevention and control. If your child has not visited your family dentist within the last six months, we advise you to make an appointment immediately. After the dental appointment, the signed form should be returned to the school your child will be attending.

Report of Dental Examination:

A. ☐ No dental treatment is necessary.

B. ☐ All necessary dental treatment has been completed.

C. ☐ Treatment is in progress.

Further recommendations: ______________________________

____

____

______________________ Date

______________________ Signature of Dentist