PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:

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.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
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	☐	☐	

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

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ 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

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

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.

Additional Comments: _____

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

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: O Male O Female BIRTHDATE _____ PHONE _____

PARENT OR GUARDIAN _____ _____ _____
LAST FIRST MIDDLE

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

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments
	Make a selection:		
	Make a selection:		
	Make a selection:		

Comments:

Person completing form: O Health Care Provider/Designee OR O 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: O YES O NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

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)

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

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
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
21757
21758
21762
21769

Frederick (Continued)
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
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
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

Queen Anne's (Continued)
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

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.