MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

HEALTH INVENTORY

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

Child's Name: _____ Birth Date: _____
Last First Middle

Name of Parent/Guardian: _____ Relationship: _____

Home Address: _____
Street City State Zip Code

Home Telephone: _____

Dear Parent/Guardian

Every child should have medical and dental health supervision periodically from birth to age 18. Even healthy children should see a doctor and dentist, at regular intervals. Health check-ups should include physical examinations and immunizations which are necessary to keep your child free of communicable disease.

Maryland law requires you to submit proof of age-appropriate immunizations on the Maryland Immunization Certificate (DHMH 896) to the center, home, or school. This must be done before your child can be admitted.

This form requests health information from you (Part I) and from your child's Health Practitioner (Part II). The section you complete will be helpful to the Health practitioner in his evaluation of your child.

It necessary that you also provide information for Form DHR/CCA 1214, This is the Emergency Information Form for Child Care Centers, Family Care Homes, and Non-public Nursery Schools and Kindergartens.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: ACADEMY CHILD DEVELOPMENT CENTER
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

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".

		YES	NO
1.	Are you concerned about your child's general health *(eating, sleeping habits, posture, teeth, skin. menstruation, weight, bowel l bladder, etc.)?*	_____	_____
2.	Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	_____	_____
	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 *(frequent earaches, difficulty hearing, etc.)?*	_____	_____
	Date of last hearing evaluation: _____ Doctor's Name: _____		
	Results: _____		
	Does your child use a hearing aid?	_____	_____
4.	Does your child have any speech problems (difficulty *having speech understood, stammering, delayed speech development, etc.)?*	_____	_____
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, give details under "Remarks".	_____	_____
	(a) Does this condition require any special health care in the child care facility or school?	_____	_____
	(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or educational needs? If YES, give details under "Remarks"	_____	_____
	(c) Does your child require any adaptive equipment?	_____	_____
7.	Do you have concerns about your child's behavior or emotional well-being which the child care provider or school should know about? If YES, give details under "Remarks".	_____	_____

REMARKS *(Clarify any "YES" answers):*

PARENT'S STATEMENT - ALL MUST SIGN AND DATE BELOW

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 AND EDUCATIONAL NEED IN DAY CARE OR SCHOOL.

Please fill in if child is school age:

I give my permission to _____ School to release _____ 's
Name of School Name of Child

health information to _____
Name of Child Care Center, Family Child Care Home, Non-public Nursery School

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 EVALUATION

To be completed by a HEALTH PRACTITIONER

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ____ / ____ / ____ . Result: _____ Positive _____ Negative
2. This child has the following which may significantly affect his/her child care or educational 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: _____

3. This child has a health condition which may require care or emergency action while at child care or school. _____ Yes _____ No

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

4. 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: _____
5. This Child requires a modified diet and/or special feeding procedures. _____ Yes _____ No
   If YES, please specify: _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

6. If child cannot fully participate in all areas of day care program, what areas should be limited or altered to suit his/her needs?
   _____
7. Does child's physical activity need to be restricted? _____ Yes _____ No
   If YES, specify: _____
8. Does this child require any specialized treatment? _____ Yes _____ No
   If YES, specify: _____
9. Does this child require any adaptive equipment (Braces, crutches, etc.)? _____ Yes _____ No
   If YES, specify type _____
   Special instructions for use: _____
10. Additional comments: _____
    _____

HEALTH PRACTIONER'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.
(Date) (Circle One)

_____ (_____)_____
Name Health Practitioner (Please Print) Telephone Number

_____ _____
Signature of Health Practitioner Date

PART III: ADDITIONAL COMMENTS

This page is 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 parents following absences may be attached to this record.

DATE	RECORDER	DETAILS