

## HEALTH INVENTORY

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

Child's Name: _____ Last First Middle	Birth Date: _____
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 from birth to age 18. Even healthy children should see a doctor and dentist at regular intervals. Health check-ups should include physical examination 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.

#### PLEASE RETURN THIS COMPLETED FORM TO:

Name of: \_\_\_\_\_  
Child Care Center, Family Child Care Home, School

Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code



**PART II: MEDICAL INFORMATION**

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/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 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: \_\_\_\_\_

8. Does this child require any specialized treatment? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify: \_\_\_\_\_

9. Does this child require any adaptive equipment (braces, crutches, etc.)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify type: \_\_\_\_\_

Special instructions for use: \_\_\_\_\_

10. Additional comments: \_\_\_\_\_

**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)

\_\_\_\_\_  
Name of Health Practitioner (Please Print)

( ) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature of Health Practitioner  
OCC 1215 (Revised 1/06) - All previous editions are obsolete

\_\_\_\_\_  
Date

