

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____			Sex	
Last		First		Middle		Mo / Day / Yr	
M <input type="checkbox"/> F <input type="checkbox"/>							
Address: _____							
Number		Street		Apt#		City	
				State		Zip	
Parent/Guardian Name(s)		Relationship		Phone Number(s)			
				W: _____		C: _____	
				W: _____		C: _____	
				H: _____		H: _____	
Your Child's Routine Medical Care Provider				Your Child's Routine Dental Care Provider		Last Time Child Seen for Physical Exam:	
Name: _____				Name: _____		Dental Care:	
Address: _____				Address: _____		Any Specialist :	
Phone # _____				Phone _____			
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 (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>					
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>					
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>					
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>					
Bladder	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>					
Bowels	<input type="checkbox"/>	<input type="checkbox"/>					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>					
Coughing	<input type="checkbox"/>	<input type="checkbox"/>					
Communication	<input type="checkbox"/>	<input type="checkbox"/>					
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Feeding	<input type="checkbox"/>	<input type="checkbox"/>					
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>					
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>					
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>					
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>					
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>					
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>					
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>					
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>					
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?							
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)							
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)							
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____							
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.							
Signature of Parent/Guardian _____						Date _____	

PART II - CHILD HEALTH ASSESSMENT
To be completed ONLY by Physician/Nurse Practitioner

Child's Name:	Birth Date:	Sex
Last First Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

1. Does the child named above have a diagnosed medical condition?
 No Yes, describe:

2. 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:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 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: http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

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.
Parent/Guardian Signature: _____ Date: _____

5. 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).

6. Should there be any restriction of physical activity in child care?
 No Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No		

_____ **has had a complete physical examination and any concerns have been noted above.**
(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date: