

## 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 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, teeth, skin, menstruation, weight, bowel/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 education 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 teacher 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 NEEDS IN CHILD CARE OR SCHOOL.

Please fill in, if child is school age:

I give my permission to \_\_\_\_\_ School to release \_\_\_\_\_ 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 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

\_\_\_\_\_  
Date

