

**Maryland Schools  
Record of  
Physical Examination**

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement.***  
(<http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm>)
- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade. A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at:***  
<http://www.edcp.org/pdf/DHMH896new.pdf>.
- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1<sup>st</sup> grade. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:***  
<http://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf>.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a families religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

**Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.**

**If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at <http://www.marylandpublicschools.org/NR/rdonlyres/8D9E900E-13A9-4700-9AA8-5529C5F4C749/3341/medicationform404.pdf>. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene

Maryland State Department of Education

**Records Retention - This form must be retained in the school record until the student is age 21.**

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

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month			Year	
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
<b>ASSESSMENT OF STUDENT HEALTH</b> To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication? No      Yes      Name(s) of Medications: _____				
Is your child on any special treatments? (nebulizer, epi-pen, etc.) .. No      Yes      Treatment _____				
Does your child require any special procedures? (catheterization, etc.) No      Yes				
Parent/Guardian Signature _____			Date: _____	

# Howard County Public School System Health Survey Form

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Entering School: \_\_\_\_\_ Last School Attended with City/State: \_\_\_\_\_

HAS YOUR CHILD EVER ATTENDED A MARYLAND PUBLIC SCHOOL? YES \_\_\_\_ NO \_\_\_\_

## Contact Information

Name of Person Giving Information: \_\_\_\_\_ Relationship: \_\_\_\_\_

What is the best phone number to reach you at while your student is at school? \_\_\_\_\_

Would you like to be contacted by email? If YES, please provide best email address \_\_\_\_\_

Can we reach you by text? If YES, please provide cell phone number \_\_\_\_\_

## Medical Information

Does the student have:

- A Physician? YES: \_\_\_\_ Name and telephone number physician: \_\_\_\_\_  
NO: \_\_\_\_ Do you need help finding a physician? YES \_\_\_\_ NO \_\_\_\_
- Date of last Physical Exam: \_\_\_\_\_
- Date of last Dental Exam: \_\_\_\_\_
- Date of last Vision Exam: \_\_\_\_\_
- Health Insurance Coverage? YES \_\_\_\_ NO \_\_\_\_

## Health History

1. Will the student require medication to be given at school? YES \_\_\_\_ NO \_\_\_\_  
*If YES, a Medication Order Form must be completed for each prescription and over the counter medication to be given during school.*
2. What medications are taken at home: \_\_\_\_\_

## Medical Concerns:

Yes	No	
		a. Allergies? (please list) _____
		b. Is the NUT-FREE table required for this student? _____
		c. Medical Conditions? For example: ADHD, Diabetes, Seizures, Asthma, Cardiac, Blood Disorders, Cancer, etc. (please list) _____
		d. Hospitalizations or Operations? (please list) _____
		e. Physical Handicapping Conditions? (please list) _____
		f. Activity Restrictions? If yes, a Physical Education Activity Restriction form must be completed by a physician. _____
		g. Assistive Devices? (please list) _____
		h. Mental Health Issues? (please list) _____
		i. Speech Difficulties/Developmental Delays? (please list) _____
		j. Vision Difficulties? For example: Wears Glasses or Contacts, Crossed Eyes,, etc. (please list) _____
		k. Hearing Difficulties? _____
		l. Any Other Health Concerns? For example: eating/sleeping habits, posture, skin/teeth, weight, daytime wetting/stooling concerns, etc. (please list) _____

**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).

PARENT OR  
GUARDIAN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST MIDDLE

☐ YES ☐ NO

**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.**

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

Office Address: \_\_\_\_\_

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)

<u>Allegany</u>	<u>Baltimore Co. (Continued)</u>	<u>Carroll</u>	<u>Frederick (Continued)</u>	<u>Kent</u>	<u>Prince George's (Continued)</u>	<u>Queen Anne's (Continued)</u>
ALL	21212	21155	21776	21610	20737	21640
	21215	21757	21778	21620	20738	21644
<u>Anne Arundel</u>	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		<u>Garrett</u>	<u>Montgomery</u>	20752	<u>Somerset</u>
21225	21229	<u>Charles</u>	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	<u>Harford</u>	20812	20782	<u>St. Mary's</u>
	21237	20662	21001	20815	20783	20606
<u>Baltimore Co.</u>	21239		21010	20816	20784	20626
21027	21244	<u>Dorchester</u>	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	<u>Frederick</u>	21082	20868	20790	
21085	21286	20842	21085	20877	20791	<u>Talbot</u>
21093		21701	21130	20901	20792	21612
21111	<u>Baltimore City</u>	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	<u>Howard</u>	<u>Prince George's</u>	<u>Queen Anne's</u>	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	<u>Caroline</u>	21758		20712	21620	<u>Washington</u>
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						<u>Wicomico</u>
						ALL
						<u>Worcester</u>
						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.



## SCHOOL HEALTH SERVICES Dental Health Form

Dear Parents/Guardian:

Our school health program is designed to improve, protect, and promote the health of students. As a part of this program, we strongly urge families to have children visit their dentist at least once a year for a dental examination and any care that may be needed. In the interest of better dental health, please have your dentist examine your child and complete this form. Please return the completed form to the health room at your child's school.

Help in locating a dentist may be obtained by contacting the Maryland State Dental Association on 410-964-2800 ([www.msda.com](http://www.msda.com)).

Help in obtaining health care insurance that includes dental care may be available. For more information on Maryland Children's Health Program, call the Howard County Health Department, 410-313-6300 or 410-313-7500.

Thank you for your cooperation.

Name \_\_\_\_\_

School \_\_\_\_\_

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### Report of Dental Examination

This is to certify that I have examined the teeth of \_\_\_\_\_ and:

- ☐ All necessary dental work has been completed.
- ☐ Treatment is in progress.
- ☐ No dental work is necessary.

Further recommendations \_\_\_\_\_

Dentist signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please return this form to the health room at your child's school.**

# MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME \_\_\_\_\_  
LAST
FIRST
MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 OR  
 GUARDIAN ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

## RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type										Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr						
1										1				
2										2				
3											Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4											_____	_____	_____	_____
5											_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name  
 Office Address/ Phone Number

1. \_\_\_\_\_  
 Signature Title Date  
 (Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

### MEDICAL CONTRAINDICATION:

**Please check the appropriate box to describe the medical contraindication.**

This is a: ☐ Permanent condition OR ☐ Temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Medical Provider / LHD Official

### 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 vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

### Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

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

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
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1. Does the child have a diagnosed medical condition?  
No Yes \_\_\_\_\_

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school?  
(e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes,  
please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".  
No Yes \_\_\_\_\_

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.  
No Yes \_\_\_\_\_  
(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.  
No Yes \_\_\_\_\_

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

**PART II - SCHOOL HEALTH ASSESSMENT - continued**To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) \_\_\_\_\_ has had a complete physical examination and has:

- • no evident problem that may affect learning or full school participation    • • problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)

Phone No.

Physician/Nurse Practitioner Signature

Date