

BALTIMORE COUNTY DEPARTMENT OF HEALTH
Division of School Health Services



HEALTH INVENTORY

To Parents or Guardians:

A physical examination is recommended for all children prior to entrance into school and again upon entrance into Middle School. An Examination is also requested for all children transferring into a school.

To do the best possible job of teaching your child, his or her teachers should understand and be aware of special health and developmental needs. This requires some information from you and from the child's physician.

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

Maryland law requires all school students in nursery through twelfth grade to show evidence of complete primary immunizations against certain childhood communicable diseases. Exemptions from immunization requirements are permitted only if a parent objects to immunization because of bona fide religious beliefs and practices. A Maryland Immunization Certificate Form (DHMH 896) must be completed along with the required immunizations before a student can attend school.

Please complete this Health Inventory form and return it to your child's school as quickly as possible.

You are asked to complete Part I of this Health Inventory Form. Part II is to be completed by the physician or nurse practitioner who examines your child.

PART I - HEALTH ASSESSMENT
 -To be completed by parent/guardian-

Student Name (Last, First, Middle)	Birthdate (Mo/Day/Yr)	Sex (M/F)	School	Grade
Address (Number, Street, City, State, Zip)			Phone No:	
Parent/Guardian Names:				
Where do you usually take your child for medical care? Name:			Address: Phone No:	
When was the last time your child had a physical exam:			Month: Year:	
Where do you usually take your child for dental care? Name:			Address: Phone No:	
ASSESSMENT OF STUDENT HEALTH				
To the best of your knowledge, does your child have a history of or any problems with the following. Please check "yes" or "no":				
	Yes	No	Comments	
Birth Defects				
Prematurity				
Hospitalization (When, Where)				
Concussion (Head Injury)				
Surgery				
Lead Poisoning				
Eye or Vision Problems				
Ear Problems or Deafness				
Speech Problems				
Cerebral Palsy				
Meningitis				
Heart Problems				
Serious Allergic Reactions			Please list:	
Behavior or Emotional Problem			Please list:	
Allergies (Food, Insects, Drugs, Etc.)				
Asthma			Please describe severity:	
Sickle Cell Disease				
Diabetes				
Seizures				
Bleeding Problems				
Limits on Activity				
Problem with Bladder or Bowels				
Chicken Pox			If yes, Month & Year:	
Does your student take any medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Medication _____				
Parent/Guardian Signature _____ Date _____				

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

Student Name (Last, First, Middle)	Birthdate (Mo/Day/Yr)	Sex (M/F)	School	Grade
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Address (Number, Street, City, State, Zip) Phone No: _____

1. 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?) If yes, please DESCRIBE.

No Yes _____

2. Is the child on long-term technology assistance? Please note specifics.

No Yes _____

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing an "X" in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/Impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			

REMARKS: (Please explain any "yes"; include recommendations for referral and treatment.)

4. RECORD OF IMMUNIZATIONS-If possible, record all the child's doses with dates on the DHMH 896, MARYLAND IMMUNIZATION CERTIFICATE form. This section is only to be used if the DHMH 896 is not available.

RECORD OF IMMUNIZATION

DOSE No.	VACCINE TYPE									
	DTP-DTAP DT-TD MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	M-M-R MO/DAY/YR	VARICELLA MO/DAY/YR	PREVNAR MO DAY/YR	OTHER MO/DAY/YR	OTHER MO/DAY/YR	
1										
2										
3										
4										
5										

*Blood Test verification of immunity and date may be entered in lieu of vaccination date.

PHYSICIAN HEALTH OFFICIAL SCHOOL OFFICIAL OR DAY CARE PROVIDER	TO THE BEST OF MY KNOWLEDGE THE VACCINES LISTED ABOVE WERE ADMINISTERED AS INDICATED	Signed _____ (Parent Signature not Valid) Title _____ Date _____
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MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 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 #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Heb B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td _____	Tdap _____	Other _____	Other _____
4													
5													

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

Clinic / Office Name

- _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)
- _____
Signature Title Date
- _____
Signature Title Date

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

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
 Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a permanent condition temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

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 immunizations 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 directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per 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 DHMH 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; and (h) Varicella.”

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 DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization).

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.EDCP.org (Immunization).

BALTIMORE COUNTY DEPARTMENT OF HEALTH

Division of School Health



SCHOOL DENTAL HEALTH RECORD

Please take this form to your family dentist when your child has his next dental appointment.
Have your dentist complete the form and have your child return the form to the school nurse.

Name of Student _____ Date _____

Name of School _____ Age _____

School Nurse _____ Grade _____

REPORT OF DENTAL EXAMINATION:

- No dental treatment is necessary
- All necessary dental treatment has been completed
- Treatment is in progress

FURTHER RECOMMENDATIONS _____

Dentist's Signature _____ Date _____

Dentist's Name _____ Phone _____

Address _____