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

**Child's Name:** _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

**Address:** _____
Number Street Apt# City State Zip

| Parent/Guardian Name(s) | Relationship | Phone Number(s) | | |
|---|---|---|---|---|
| | | W: | C: | H: |
| | | W: | C: | H: |

| Medical Care Provider | Health Care Specialist | Dental Care Provider | Health Insurance | Last Time Child Seen for |
|---|---|---|---|---|
| **Name:** | **Name:** | **Name:** | ☐ **Yes** ☐ **No** | **Physical Exam:** |
| **Address:** | **Address:** | **Address:** | **Child Care Scholarship** | **Dental Care:** |
| **Phone:** | **Phone:** | **Phone:** | ☐ **Yes** ☐ **No** | **Specialist:** |

**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 | ☐ | ☐ | |
| Asthma or Breathing | ☐ | ☐ | |
| ADHD | ☐ | ☐ | |
| Autism Spectrum Disorder | ☐ | ☐ | |
| Behavioral or Emotional | ☐ | ☐ | |
| Birth Defect(s) | ☐ | ☐ | |
| Bladder | ☐ | ☐ | |
| Bleeding | ☐ | ☐ | |
| Bowels | ☐ | ☐ | |
| Cerebral Palsy | ☐ | ☐ | |
| Communication | ☐ | ☐ | |
| Developmental Delay | ☐ | ☐ | |
| Diabetes Mellitus | ☐ | ☐ | |
| Ears or Deafness | ☐ | ☐ | |
| Eyes | ☐ | ☐ | |
| Feeding/Special Dietary Needs | ☐ | ☐ | |
| Head Injury | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Hospitalization (When, Where, Why) | ☐ | ☐ | |
| Lead Poisoning/Exposure | ☐ | ☐ | |
| Life Threatening/Anaphylactic Reactions | ☐ | ☐ | |
| Limits on Physical Activity | ☐ | ☐ | |
| Meningitis | ☐ | ☐ | |
| Mobility-Assistive Devices if any | ☐ | ☐ | |
| Prematurity | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |
| Sensory Impairment | ☐ | ☐ | |
| Sickle Cell Disease | ☐ | ☐ | |
| Speech/Language | ☐ | ☐ | |
| Surgery | ☐ | ☐ | |
| Vision | ☐ | ☐ | |
| Other | ☐ | ☐ | |

**Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?**

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

**Does your child receive any special treatments?** (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

**Does your child require any special procedures?** (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

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.**

_____
Printed Name and Signature of Parent/Guardian Date

## PART II - CHILD HEALTH ASSESSMENT
### To be completed *ONLY* by Health Care Provider

| **Child's Name:** Last First Middle | **Birth Date:** Month / Day / Year | **Sex** M ☐ F ☐ |
|---|---|---|

**1.** Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

**2.** Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

**3.** 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:

**4.** Health Assessment Findings

| **Physical Exam** | **WNL** | **ABNL** | **Not Evaluated** | **Health Area of Concern** | **NO** | **YES** | **DESCRIBE** |
|---|---|---|---|---|---|---|---|
| Head | ☐ | ☐ | ☐ | Allergies | ☐ | ☐ | |
| Eyes | ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | |
| Ears/Nose/Throat | ☐ | ☐ | ☐ | Attention Deficit/Hyperactivity | ☐ | ☐ | |
| Dental/Mouth | ☐ | ☐ | ☐ | Autism Spectrum Disorder | ☐ | ☐ | |
| Respiratory | ☐ | ☐ | ☐ | Bleeding Disorder | ☐ | ☐ | |
| Cardiac | ☐ | ☐ | ☐ | Diabetes Mellitus | ☐ | ☐ | |
| Gastrointestinal | ☐ | ☐ | ☐ | Eczema/Skin issues | ☐ | ☐ | |
| Genitourinary | ☐ | ☐ | ☐ | Feeding Device/Tube | ☐ | ☐ | |
| Musculoskeletal/orthopedic | ☐ | ☐ | ☐ | Lead Exposure/Elevated Lead | ☐ | ☐ | |
| Neurological | ☐ | ☐ | ☐ | Mobility Device | ☐ | ☐ | |
| Endocrine | ☐ | ☐ | ☐ | Nutrition/Modified Diet | ☐ | ☐ | |
| Skin | ☐ | ☐ | ☐ | Physical illness/impairment | ☐ | ☐ | |
| Psychosocial | ☐ | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | |
| Vision | ☐ | ☐ | ☐ | Seizures/Epilepsy | ☐ | ☐ | |
| Speech/Language | ☐ | ☐ | ☐ | Sensory Impairment | ☐ | ☐ | |
| Hematology | ☐ | ☐ | ☐ | Developmental Disorder | ☐ | ☐ | |
| Developmental Milestones | ☐ | ☐ | ☐ | Other: | | | |

**REMARKS:** (Please explain any abnormal findings.)

| **5.** Measurements | Date | Results/Remarks |
|---|---|---|
| Tuberculosis Screening/Test, if indicated | | |
| Blood Pressure | | |
| Height | | |
| Weight | | |
| BMI % tile | | |
| Developmental Screening | | |

**6.** 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).**
**https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms**

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

**8.** Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

**9.** **RECORD OF IMMUNIZATIONS** – MDH 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: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

**10.** **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

| Health Care Provider Name (Type or Print): | Phone Number: | Health Care Provider Signature: | Date: |
|---|---|---|---|
| | | | |