

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

# HEALTH INVENTORY

## Information and Instructions for Parents/Guardians

### REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered, or approved child care or nursery school:

- **A physical examination** by a health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

### EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

### INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

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

|                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    |                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Child's Name: _____                                                                                                                                                                                                                                                                                      |                                                                                |                                                                              | Birth date: _____                                                                                                                                                                |                                                                                                    | Sex<br>M <input type="checkbox"/> F <input type="checkbox"/> |
| Address: _____<br><div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>                                                                                                                                         |                                                                                |                                                                              | Mo / Day / Yr                                                                                                                                                                    |                                                                                                    |                                                              |
| Number _____ Street _____                                                                                                                                                                                                                                                                                |                                                                                | Apt# _____                                                                   | City _____                                                                                                                                                                       |                                                                                                    | State _____ Zip _____                                        |
| <b>Parent/Guardian Name(s)</b>                                                                                                                                                                                                                                                                           |                                                                                | <b>Relationship</b>                                                          | <b>Phone Number(s)</b>                                                                                                                                                           |                                                                                                    |                                                              |
|                                                                                                                                                                                                                                                                                                          |                                                                                | W: _____                                                                     | C: _____                                                                                                                                                                         | H: _____                                                                                           |                                                              |
|                                                                                                                                                                                                                                                                                                          |                                                                                | W: _____                                                                     | C: _____                                                                                                                                                                         | H: _____                                                                                           |                                                              |
| <b>Medical Care Provider</b><br>Name: _____<br>Address: _____<br>Phone: _____                                                                                                                                                                                                                            | <b>Health Care Specialist</b><br>Name: _____<br>Address: _____<br>Phone: _____ | <b>Dental Care Provider</b><br>Name: _____<br>Address: _____<br>Phone: _____ | <b>Health Insurance</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Child Care Scholarship</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Last Time Child Seen for</b><br>Physical Exam: _____<br>Dental Care: _____<br>Specialist: _____ |                                                              |
| <b>ASSESSMENT OF CHILD'S HEALTH</b> - 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                                                                                                                                                                                                                                                                                                | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Asthma or Breathing                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| ADHD                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Autism Spectrum Disorder                                                                                                                                                                                                                                                                                 | <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"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Communication                                                                                                                                                                                                                                                                                            | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Developmental Delay                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Diabetes Mellitus                                                                                                                                                                                                                                                                                        | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Ears or Deafness                                                                                                                                                                                                                                                                                         | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Eyes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Feeding/Special Dietary Needs                                                                                                                                                                                                                                                                            | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Head Injury                                                                                                                                                                                                                                                                                              | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Heart                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Hospitalization (When, Where, Why)                                                                                                                                                                                                                                                                       | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Lead Poisoning/Exposure                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Life Threatening/Anaphylactic 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"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Sensory Impairment                                                                                                                                                                                                                                                                                       | <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"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Vision                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Other                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/>                                                       | <input type="checkbox"/>                                                     |                                                                                                                                                                                  |                                                                                                    |                                                              |
| <b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.                                                                   |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    |                                                              |
| <b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    |                                                              |
| <b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)<br><input type="checkbox"/> No <input type="checkbox"/> 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.                                                                                                                             |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    |                                                              |
| <b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>                                                                                                                                                                                      |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    |                                                              |
| Printed Name and Signature of Parent/Guardian _____                                                                                                                                                                                                                                                      |                                                                                |                                                                              |                                                                                                                                                                                  |                                                                                                    | Date _____                                                   |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                          |                          |                                 |                                                              |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--------------------------------------------------------------|--------------------------|
| Child's Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                          | Birth Date: _____        |                                 | Sex<br>M <input type="checkbox"/> F <input type="checkbox"/> |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Last                     | First                    | Middle                   | Month / Day / Year              |                                                              |                          |
| 1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                                 |                                                              |                          |
| 2. Does the child receive care from a Health Care Specialist/Consultant?<br><input type="checkbox"/> No <input type="checkbox"/> 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.<br><input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                 |                                                              |                          |
| 4. Health Assessment Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                                 |                                                              |                          |
| Physical Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | WNL                      | ABNL                     | Not Evaluated            | Health Area of Concern          | NO                                                           | YES                      |
| Head                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                       | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Eyes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                          | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Ears/Nose/Throat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Attention Deficit/Hyperactivity | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Dental/Mouth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autism Spectrum Disorder        | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorder               | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Cardiac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus               | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Gastrointestinal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema/Skin issues              | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Genitourinary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feeding Device/Tube             | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Musculoskeletal/orthopedic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lead Exposure/Elevated Lead     | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Neurological                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mobility Device                 | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Endocrine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nutrition/Modified Diet         | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical illness/impairment     | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Psychosocial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems            | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Vision                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Epilepsy               | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Speech/Language                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensory Impairment              | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Hematology                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Developmental Disorder          | <input type="checkbox"/>                                     | <input type="checkbox"/> |
| Developmental Milestones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other:                          |                                                              |                          |
| REMARKS: (Please explain any abnormal findings.)<br>_____<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                          |                          |                                 |                                                              |                          |
| 5. Measurements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          | Date                     |                          | Results/Remarks                 |                                                              |                          |
| Tuberculosis Screening/Test, if indicated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                                 |                                                              |                          |
| Blood Pressure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                          |                          |                                 |                                                              |                          |
| Height                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                 |                                                              |                          |
| Weight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                                 |                                                              |                          |
| BMI % tile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                          |                          |                                 |                                                              |                          |
| Developmental Screening                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                          |                          |                                 |                                                              |                          |
| 6. Is the child on medication?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis:<br>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).<br><a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                 |                                                              |                          |
| 7. Should there be any restriction of physical activity in child care?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                 |                                                              |                          |
| 8. Are there any dietary restrictions?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                                 |                                                              |                          |
| 9. <b>RECORD OF IMMUNIZATIONS</b> – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 896.)                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                          |                          |                                 |                                                              |                          |
| 10. <b>RECORD OF LEAD TESTING</b> - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 4620)<br><br>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: |
|                                            |               |                                 |       |

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

Environmental Health Bureau  
mdh.envhealth@maryland.gov

# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

## How To Use This Form

- ➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

## Frequently Asked Questions

### **1. Who should be tested for lead?**

All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

### **2. What is the blood lead reference value, and how is it interpreted?**

Maryland follows the [CDC blood lead reference value](#), which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

### **3. If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

Yes, if a capillary test shows a blood lead level of  $\geq 3.5$  µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See [Table 1](#) (CDC) for the recommended schedule.

### **4. What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (<https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm>).

### **5. What programs or resources are available to families with a child with lead exposure?**

Maryland and local jurisdictions have programs for families with a child exposed to lead:

- Maryland Home Visiting Services for Children with Lead Poisoning
- Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: <https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx>.

Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:  
<https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx>

Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.

Phone: (610) 519-3478 or Toll Free: (833) 362-2243

Website: <https://www1.villanova.edu/university/nursing/macche.html>