

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____ Last First Middle Birth Date
Name of Parent or Guardian _____ Relationship
Home Address _____
City _____ State _____ Zip Code _____
Check Best Telephone Number to Reach You: <input type="checkbox"/> Home #: _____ <input type="checkbox"/> Work #: _____ <input type="checkbox"/> Cell #: _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

**Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.**

**PLEASE RETURN THIS COMPLETED FORM TO:**

Name of Child Care Facility: \_\_\_\_\_

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

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION**

To be completed by **PARENT/GUARDIAN**

**CHILD'S NAME:** \_\_\_\_\_

**IMPORTANT:** COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	<b>YES</b>	<b>NO</b>
1. Are you concerned about your child's general health ( <i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i> )?	_____	_____
2. Does your child have any eye problems ( <i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i> )? Date of last eye examination: ____/____/____      Doctor's Name: _____ Results: _____ Does your child wear glasses? _____ Contact lenses? _____	_____	_____
3. Does your child have any ear or hearing problems ( <i>frequent earaches, difficulty hearing, etc.</i> )? Date of last hearing evaluation ____/____/____      Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	_____	_____
4. Does your child have any speech problems ( <i>difficulty having speech understood, stammering, delayed speech development, etc.</i> )?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: (a) Does this condition require any special health care in the child care facility? _____ (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? _____ (c) Does your child require any special adaptations or adaptive equipment? _____	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

**REMARKS** (*Provide further explanation for all "YES" answers*): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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.**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**PART II: MEDICAL INFORMATION**

To be completed by a **HEALTH PRACTITIONER**

**CHILD'S NAME:** \_\_\_\_\_

1. Date of this child's most recent tuberculin test: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_ Positive \_\_\_ Negative

**Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.**

2. Date of this child's lead screening: \_\_\_/\_\_\_/\_\_\_ Blood lead test dates: Test 1: \_\_\_/\_\_\_/\_\_\_ Test 2: \_\_\_/\_\_\_/\_\_\_

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS) \_\_\_\_\_
- a. Vision problem  YES  NO \_\_\_\_\_
  - b. Hearing problem  YES  NO \_\_\_\_\_
  - c. Speech or language problem  YES  NO \_\_\_\_\_
  - d. Other physical illness or impairment  YES  NO \_\_\_\_\_
  - e. Mental, emotional or behavior problems  YES  NO \_\_\_\_\_
  - f. Developmental delays  YES  NO \_\_\_\_\_
  - g. Allergies  YES  NO \_\_\_\_\_

Significant physical findings, comments and recommendations: \_\_\_\_\_

4. This child has a health condition which may require care or emergency action while at child care.  YES  NO  
 If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): \_\_\_\_\_

Recommendations: \_\_\_\_\_

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.  
 YES  NO If YES, please specify: \_\_\_\_\_

6. This child requires a modified diet and/or special feeding procedures.  YES  NO  
 If YES, please specify: \_\_\_\_\_

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?  
 \_\_\_\_\_

8. Does this child's physical activity need to be restricted?  YES  NO  
 If YES, please specify: \_\_\_\_\_

9. Does this child require any specialized treatment?  YES  NO  
 If YES, please specify: \_\_\_\_\_

10. Does this child require any adaptive equipment (braces, crutches, etc.)?  YES  NO  
 If YES, please specify type: \_\_\_\_\_  
 Special instructions for use: \_\_\_\_\_

**RECORD OF IMMUNIZATIONS**

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

