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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 physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- ° **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:

<http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland-immunization-certification-form-dhmh-896-fbruary-2014.pdf>

- ° **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: [http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh\\_4620\\_bloodleadtestingcertificate\\_2016.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf)

### EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their 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 provider or child care personnel who have a legitimate care responsibility for your child.

### INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

<http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

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**PART I - HEALTH ASSESSMENT**

To be completed by parent or guardian

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex  M  F

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

Number Street Apt# City State Zip

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

<b>Your Child's Routine Medical Care Provider</b> Name: Address: Phone #	<b>Your Child's Routine Dental Care Provider</b> Name: Address: Phone	Last Time Child Seen for Physical Exam: Dental Care: Any Specialist :
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**ASSESSMENT OF CHILD'S HEALTH** - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<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"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening Allergic 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"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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

No  Yes, name(s) of medication(s): \_\_\_\_\_

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

No  Yes, type of treatment: \_\_\_\_\_

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

No  Yes, what procedure(s): \_\_\_\_\_

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 \_\_\_\_\_



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## PART II - CHILD HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

<b>Child's Name:</b> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 20%;">Last</span> <span style="width: 20%;">First</span> <span style="width: 20%;">Middle</span> </div>	<b>Birth Date:</b> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 20%;">Month</span> <span style="width: 10%;">Day</span> <span style="width: 20%;">Year</span> </div>	<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
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1. Does the child named above have a diagnosed medical condition?  
 No     Yes, describe: \_\_\_\_\_

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE and describe emergency action(s) on the emergency card.  
 No     Yes, describe: \_\_\_\_\_

**3. PE Findings**

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: [http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland\\_immunization\\_certification\\_form\\_dhmh\\_896\\_-\\_february\\_2014.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf))

**RELIGIOUS OBJECTION:**  
 I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

5. Is the child on medication?  
 No     Yes, indicate medication and diagnosis:  
**(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).**

6. Should there be any restriction of physical activity in child care?  
 No     Yes, specify nature and duration of restriction: \_\_\_\_\_

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620	<input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1                      Test #2                      Test #1                      Test #2

\_\_\_\_\_ has had a complete physical examination and any concerns have been noted above.  
 (Child's Name)

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
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**HOW TO USE THIS FORM**

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

**At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born  
BEFORE January 1, 2015)**

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

**Lead Risk Assessment Questionnaire Screening Questions:**

1. Lives in or regularly visits a house building built before 1978 with peeling or chipping paint, recent ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.



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**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

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

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

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

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

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

**Vaccines Type**

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

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

Clinic / Office Name \_\_\_\_\_  
 Office Address/ Phone Number \_\_\_\_\_

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

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

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

**MEDICAL CONTRAINDICATION:**

Please check the appropriate box to describe the medical contraindication.

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

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

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

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

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

### MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

**Instructions:** Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

#### BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME \_\_\_\_\_  
 CHILD'S ADDRESS \_\_\_\_\_  
 STREET ADDRESS (with Apartment Number) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 SEX:  Male  Female BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE \_\_\_\_\_  
 PARENT OR GUARDIAN \_\_\_\_\_  
 LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

#### BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

- Was this child born on or after January 1, 2015?  YES  NO
- Has this child ever lived in one of the areas listed on the back of this form?  YES  NO
- Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)?  YES  NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

#### BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

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

Comments:

Person completing form:  Health Care Provider Designee OR  School Health Professional Designee

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

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

#### BOX D – Bona Fide Religious Beliefs

I am the parent guardian of the child identified in Box A. above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done:  YES  NO

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

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



### EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____	C: _____	H: _____
		W: _____		
		Place of Employment: _____	C: _____	H: _____
		W: _____		

Name of Person Authorized to Pick Up Child (daily) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Any Changes/Additional Information \_\_\_\_\_

ANNUAL UPDATES \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

-----  
OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

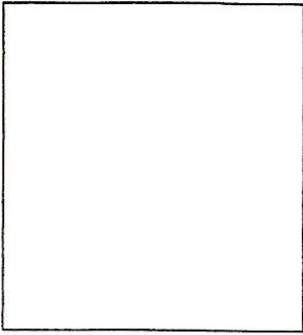
\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number



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MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM



Child Care Program: \_\_\_\_\_

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.

Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_  
(PRN=as needed)

If PRN, for what symptoms: \_\_\_\_\_

Possible side effects & special instructions: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

Month / Day / Year

Month / Day / Year (not to exceed 1 year)

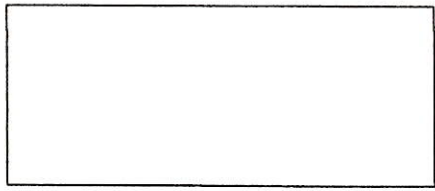
Known Food or Drug: Allergies? Yes No If Yes, please explain \_\_\_\_\_

Prescriber's Name/Title \_\_\_\_\_  
(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

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

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/we certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  
(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.

Prescriber's authorization: \_\_\_\_\_  
Signature Date

Parental approval: \_\_\_\_\_  
Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received:  YES  NO

Medication was received by: \_\_\_\_\_  
Signature of Person Receiving Medication and Reviewing the Form Date

100} 10

**MEDICATION ADMINISTERED**

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:			Date of Birth:	
Medication Name:			Dosage:	
Route:			Time(s) to administer:	
DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE