**Maryland Schools**
**Record of**
**Physical Examination**

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** *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.* (http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** *A Maryland Immunization Certification form for newly enrolling students 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 school. This form can be found at: http://www.edcp.org/pdf/DHMH896new.pdf.*

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** *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://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a families religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

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

**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 in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at** http://www.marylandpublicschools.org/NR/rdonlyres/8D9E900E-13A9-4700-9AA8-5529C5F4C749/3341/medicationform404.pdf. **If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene Maryland State Department of Education
**Records Retention - This form must be retained in the school record until the student is age 21.**

## PART I - HEALTH ASSESSMENT

### To be completed by parent or guardian

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex (M/F) | Name of School | Grade |
|---|---|---|---|---|
| | | | | |

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

| | Yes | No | Comments |
|---|---|---|---|
| Allergies (Food, Insects, Drugs, Latex) | | | |
| Allergies (Seasonal) | | | |
| Asthma or Breathing Problems | | | |
| Behavior or Emotional Problems | | | |
| Birth Defects | | | |
| Bleeding Problems | | | |
| Cerebral Palsy | | | |
| Dental | | | |
| Diabetes | | | |
| Ear Problems or Deafness | | | |
| Eye or Vision Problems | | | |
| Head Injury | | | |
| Heart Problems | | | |
| Hospitalization (When, Where) | | | |
| Lead Poisoning/Exposure | | | |
| Learning problems/disabilities | | | |
| Limits on Physical Activity | | | |
| Meningitis | | | |
| Prematurity | | | |
| Problem with Bladder | | | |
| Problem with Bowels | | | |
| Problem with Coughing | | | |
| Seizures | | | |
| Serious Allergic Reactions | | | |
| Sickle Cell Disease | | | |
| Speech Problems | | | |
| Surgery | | | |
| Other | | | |

Does your child take any medication?

☐No ☐Yes Name(s) of Medications: _____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

☐No ☐Yes Treatment _____

Does your child require any special procedures? (catheterization, etc.)

☐No ☐Yes

Parent/Guardian Signature _____ Date: _____

## PART II - SCHOOL HEALTH ASSESSMENT

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

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex (M/F) | Name of School | Grade |
|---|---|---|---|---|
| | | | | |

1. Does the child have a diagnosed medical condition?
   ☐No ☐Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   ☐No ☐Yes _____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

| Physical Exam | WNL | ABNL | Area of Concern | Health Area of Concern | YES | NO |
|---|---|---|---|---|---|---|
| Head | | | | Attention Deficit/Hyperactivity | | |
| Eyes | | | | Behavior/Adjustment | | |
| ENT | | | | Development | | |
| Dental | | | | Hearing | | |
| Respiratory | | | | Immunodeficiency | | |
| Cardiac | | | | Lead Exposure/Elevated Lead | | |
| GI | | | | Learning Disabilities/Problems | | |
| GU | | | | Mobility | | |
| Musculoskeletal/orthopedic | | | | Nutrition | | |
| Neurological | | | | Physical Illness/Impairment | | |
| Skin | | | | Psychosocial | | |
| Endocrine | | | | Speech/Language | | |
| Psychosocial | | | | Vision | | |
| | | | | Other | | |

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. _____
   ☐No ☐Yes
   **(A medication administration form must be completed for medication administration in school).**

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   ☐No ☐Yes _____

| 7. **Screenings** | **Results** | **Date Taken** |
|---|---|---|
| Tuberculin Test | | |
| Blood Pressure | | |
| Height | | |
| Weight | | |
| BMI %tile | | |
| Lead Test | Optional | |

## PART II - SCHOOL HEALTH ASSESSMENT - continued

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

(Child's Name) _____ has had a complete physical examination and has

☐ no evident problem that may affect learning or full school participation ☐ problems noted above

_____

Additional Comments:

| Physician/Nurse Practitioner (Type or Print) | Phone No. | Physician/Nurse Practitioner Signature | Date |
|---|---|---|---|
| | | | |

DPS 2300/6 (taken from Health Dept.) 3/06

# 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 _____ / _____ / _____
LAST FIRST MIDDLE

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: _____

# 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.

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

Clinic / Office Name
Office Address/ Phone Number

**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: _____