

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.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE _____/_____/_____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR
 GUARDIAN ADDRESS _____ CITY _____ ZIP _____

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4									
5	DOSE #5												

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

Clinic / Office Name
Office Address/ Phone Number

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.

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: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

CAFCP Enrollment: Yes: ___ No: ___

Meals your child will receive while in care:

BK ___ LN ___ SU ___ AM Snk ___ PM Snk ___ Evng Snk ___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (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	Contact Information		
		Email:	C:	W:
			H:	Employer:
		Email:	C:	W:
			H:	Employer:

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 _____

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

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
Last		First		Middle	
_____			Mo / Day / Yr		M <input type="checkbox"/> F <input type="checkbox"/>
Address:					
Number		Street		Apt#	City
_____		_____		_____	State
_____		_____		_____	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
_____		_____	W: _____	C: _____	H: _____
_____		_____	W: _____	C: _____	H: _____
Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for	
Name:	Name:	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Exam:	
Address:	Address:	Address:	Child Care Scholarship	Dental Care:	
Phone:	Phone:	Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specialist:	
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	<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"/>			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?					
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)					
<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.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					Date _____

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

Child's Name:			Birth Date:			Sex	
Last	First	Middle	Month / Day / Year			M <input type="checkbox"/>	F <input type="checkbox"/>
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child receive care from a Health Care Specialist/Consultant? <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. <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	DESCRIBE
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.)							
5. Measurements		Date		Results/Remarks			
Tuberculosis Screening/Test, if indicated							
Blood Pressure							
Height							
Weight							
BMI % tile							
Developmental Screening							
6. Is the child on medication? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis: (OCC 1216 Medication Authorization Form must be completed to administer medication in child care). https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms							
7. Should there be any restriction of physical activity in child care? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
8. Are there any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
9. RECORD OF IMMUNIZATIONS – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)							
10. RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620) Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.							

Additional Comments: _____

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

**Allergy and Anaphylaxis
Medication Administration Authorization Plan**

Place Child's Picture
Here (optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 to be completed by the Authorized Health Care Provider.
FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

CHILD'S NAME: _____ Date of Birth: ____/____/____ **Date of plan:** _____
 Child has **Allergy** to _____ Ingestion/Mouth Inhalation Skin Contact Sting Other _____
 Child has had anaphylaxis: Yes No
 Child has asthma: Yes No (If yes, higher chance severe reaction) Child
 may self-carry medication: Yes No
 Child may self-administer medication: Yes No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

- 1) Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911:** Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents.** Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back.** If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.**

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)		DATE (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care
Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION			
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Card updated 4. OCC 1215 Health Inventory updated 5. Modified Diet/Exercise Plan 6. Individualized Plan: IEP/IFSP 7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 is to be completed by the authorized Health Care Provider.
FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

Place Child's
Picture Here
(Optional)

CHILD'S NAME: _____ Date of Birth: ____/____/____ Date of Plan: _____

Significant Medical/Health History: _____

Seizure Triggers or Warning Signs: _____

Allergies: _____

Seizure Care Information

Seizure Type	Length (duration)	Frequency	Description

Seizure Emergency Protocol: How to respond to a seizure (Check all that apply)

First Aid – Stay. Safe. Side (refer to resource document “Seizure First Aid Guide”)

Call 911 for transport to _____ Notify parent or emergency contact

Notify Health Care Provider _____ Other _____

Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

Care after seizure: Does the child need to leave the classroom after a seizure? Yes No

What type of help is needed? (describe) _____

When can the child return to care/resume regular activity? _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form**

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION			
I authorize the child care staff to administer the medication as prescribed above. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. OCC 1214 Emergency Form updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. Staff has received additional training to administer the medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	If Yes: Trainer Name and Title _____	Date _____	
	6. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE

Individualized Treatment/Care Plan Checklist for Specialized Services

Child's Name: _____ Date of Birth: _____

Condition that requires Specialized Care: _____

Health Care Provider: _____ Phone #: _____

INSTRUCTIONS: Parents and child care providers should review and sign this form when enrolling a child with special health care needs and/or individualized treatment care plans, procedures, or medications. Attach this form to the child's treatment/care plan. The second page can be used for documentation of care, procedures, and/or medications that are not documented on any other form.

IF A MEDICAL TREATMENT PLAN INCLUDES A MEDICATION, IS SIGNED BY THE HEALTH CARE PROVIDER, AND IS ATTACHED TO THIS FORM THEN OCC 1216 IS NOT REQUIRED. For example, for diabetes medications, child care providers may accept the **Diabetes Medical Management Plan.**

	Items	Received & Reviewed			Parent Initial	Child Care Staff Initial
		Yes	No	N/A		
1	A written individualized care/treatment plan, signed by a certified professional and the parent, has been provided to the child care provider.					
2	Each staff member providing care to a child is trained, by licensed/certified professionals, in the use of specialized health care procedures or equipment. Trainer's Name & Credential: _____ Training Date: _____ Name of all staff who were trained: _____					
3	Provider agrees to allow a parent-approved adult who provides specialized services to a child in care to provide those services on the facility premises as specified in the child's individualized education or healthcare plan.					
4	Updated Emergency Form (OCC 1214).					
5	Updated Health Inventory Form (OCC 1215).					
6	Modified Menu Plan received, if applicable.					
7	Modified Physical Activity Schedule received, if applicable.					
8	Trained staff or parents are available for field trips /off-site activities.					
9	Medical Bracelet /Medical Alert Badge.					
10	Individualized Treatment/Care Plan: medical/behavioral plan/IEP/IFSP.					

PARENT/GUARDIAN AUTHORIZATION: I/We request the child care program to provide the care indicated above. I certify that I have the legal authority, understand the risks, and authorize the trained childcare staff to provide care as per the Instructions for the child named above. I agree to review and demonstrate special procedures and arrange for a certified professional to train the staff for my child's specific care components. I agree to provide the child care program with any significant updates to the child's health care condition or treatment plan. I authorize the childcare staff and the healthcare professional indicated on this form to communicate in compliance with HIPAA.

Parent/Guardian Signature: _____ Date: _____

Phone # _____ Emergency Contact Phone #: _____

Child Care Staff Signature _____ Date: _____

SEE PAGE 2 FOR DOCUMENTATION ON LOG

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/___	3. Child's picture (optional)
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Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

4. ASTHMA SEVERITY: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise Induced Peak Flow Best ___%

5. ASTHMA TRIGGERS (check all that apply): Colds URI Seasonal Allergies Pollen Exercise Animals Dust Smoke Food Weather Other _____

6. This authorization is **NOT TO EXCEED 1 YEAR FROM** ___/___/___ **TO** ___/___/___ **FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216**

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer Yes No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)					

Exercise Zone CALL 911 CALL PARENT OTHER: _____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it					

YELLOW ZONE - GETTING WORSE CALL 911 CALL PARENT OTHER: _____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)					

RED ZONE - MEDICAL ALERT/DANGER CALL 911 CALL PARENT OTHER: _____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)					

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ____/____/____
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Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

8. PRESCRIBER'S NAME/TITLE		Place Stamp Here		
TELEPHONE	FAX			
ADDRESS				
CITY	STATE	ZIP CODE		
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)				9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: OK to Self-Carry/Self -Administer Yes No

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION		
10d. CELL PHONE #	10e. HOME PHONE #		10f. WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency		
Parent/Guardian 1				
Parent/Guardian 2				
Emergency 1				
Emergency 2				

Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:	1. Medication named above was received Expiration date _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. OCC 1214 Emergency Form updated	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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**Maryland State Department of Education
Office of Child Care
Medication Administration Authorization Form**

Place Child's
Picture Here
(optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ **Date of Birth:** ____/____/____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: ____/____/____ to ____/____/____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions: _____

Known Food or Drug Allergies: Yes No If yes, please explain: _____

For School Age children only: The child may self-carry this medication: Yes No

The child may self-administer this medication: Yes No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** Yes No

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
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CELL PHONE #	HOME PHONE #	WORK PHONE #
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CHILD CARE STAFF USE ONLY

- Child Care Responsibilities:
- | | |
|---|---|
| 1. Medication named above was received. Expiration date _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Medication labeled as required by COMAR. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. OCC 1214 Emergency Form updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 4. OCC 1215 Health Inventory updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 6. Staff approved to administer medication is available onsite, field trips | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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