"Building a Foundation for Lifelong Learning"

CECIL COUNTY PUBLIC SCHOOLS
DEPARTMENT OF STUDENT SERVICES
GEORGE WASHINGTON CARVER EDUCATION LEADERSHIP CENTER
201 BOOTH STREET • ELKTON, MD 21921

phone: 410.996.5490 • fax: 410.996.1062 • www.ccps.org

D'Ette W. Devine, Ed.D.
Superintendent of Schools

Dawn K. Branch
President, Board of Education

Guidelines for Immunization Requirements
School Year 2017-2018

Kindergarten (5 years old by 09/01/2017)

Students entering kindergarten must have the following immunizations to enter the school system.

4	Doses DTP or Td Vaccine (Diphtheria and Tetanus Toxoids with Pertussis vaccine) Four doses for students less than 7 years of age. Three doses for students 7 years of age and older. Pertussis vaccine is not required after age 7.
3	Doses Polio Vaccine
2	Doses MMR (Measles, Mumps, Rubella) Vaccine - *given after 1st birthday*
2	Doses Varicella Vaccine (Chickenpox) - *given after 1st birthday* Physician documented history of chickenpox disease is acceptable in lieu of vaccine. Must list the month/year if had the disease.
3	Doses Hepatitis B Vaccine - Must list the month/day/year. We will not accept "*given at birth.*"

If your child needs additional immunizations or you need documentation of the immunizations, you need to contact your doctor or the Cecil County Health Department at (410) 996-5100.

Rev. 2/17

"Building a Foundation for Lifelong Learning"

CECIL COUNTY PUBLIC SCHOOLS

OFFICE OF EARLY CHILDHOOD EDUCATION

PRE-KINDERGARTEN / KINDERGARTEN QUESTIONNAIRE

2017-2018 School Year

Please complete the following confidential questionnaire. The information shared within this questionnaire will allow your child's teacher to get to know your child and your family.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Address: _____

Home Telephone #:_____ Cell Phone #: _____

Email: _____

Emergency Contact Name: _____ Relationship to child: _____

Phone #: _____ Email: _____

Does your child have siblings? ☐Yes ☐No

Names/ages of siblings: _____

Does your child have a daycare provider? ☐Yes ☐No

Provider Name: _____ Phone #: _____

Address: _____

Will your child be a: **Arrival:** ☐Walker ☐Car Rider ☐Bus Rider **Dismissal:** ☐Walker ☐Car ☐Bus Rider

Are there any languages other than English spoken in the home? ☐Yes ☐No

If yes, please list the language(s): _____

Does your child have:

☐ Vision concerns

☐ Hearing Concerns

☐ Speech/Language Concerns

☐ Known Allergies List: _____

☐ Large Muscle Concerns (running, jumping, climbing, etc.)

☐ Small Muscle Concerns (pinch, grasp, hold, etc.)

☐ Anxiety Concerns

Describe: _____

☐ Behavior Concerns

Describe: _____

Does your child:

- ☐ Use crayons/markers to draw
- ☐ Use scissors to cut paper
- ☐ Listen to stories read aloud
- ☐ Recall stories or events
- ☐ Talk with friends/relatives
- ☐ Follow simple, age appropriate directions
- ☐ Have the opportunity to play with other children

What are your child's hobbies and special interests? _____

_____

What are your feelings about your child's readiness for school? _____

_____

_____

What are two goals you have for your child's school experience? _____

_____

_____

What kind of technology is available to your child at home?

☐ Desktop Computer ☐ Laptop ☐ IPad/Tablet ☐ Smartphone

Does your child know how to use the technology in your home? ☐ Yes ☐ No

How often does your child use the technology in your home?

☐ Daily ☐ A few times a Week ☐ Does not have access to the technology in the home

Do you have internet access in your home? ☐ Yes ☐ No

Thank you for sharing this important information about your child. This questionnaire is filed in your child's Student Record at the end of the Pre-Kindergarten/Kindergarten year.

Enrollment Date _____ Enrollment Code _____

Grade _____ Student ID # _____

CECIL COUNTY PUBLIC SCHOOLS

ENROLLMENT DATA FORM

Child's Legal Name:

_____

Last First Middle

Birth Date: (Evidence of the birth date must be presented to the school prior to admission.)

Month _____ Day _____ Year _____ Sex ___

Place of Birth: _____

(City) (State)

Social Security Number _____

(Not required)

Other Name: (Any name other than the legal name by which the child is known. Do not list nicknames.)

_____

Primary/Home Phone No.: _____

Alternate/Cell Phone No.: _____

Email Address: _____

Residence Address: _____

Street

_____

City State Zip

Mailing Address (if different than residence address above):

_____

P.O. Box

_____

City State Zip

Evidence of Birth Date - Check One:

1 ☐ Birth Certificate
2 ☐ Hospital Certificate
3 ☐ Physician's Certificate
4 ☐ Baptismal or Church Certificate
5 ☐ Parent's Affidavit
6 ☐ Family Bible
7 ☐ Passport/Visa
8 ☐ Other _____

Check the box(es) that apply:

1 ☐ American Indian or Alaska Native
2 ☐ Asian
3 ☐ Black or African American
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ White

Hispanic/Latino ☐ **Yes** ☐ **No**

Please check if your family is living in any of the following:

☐ Shelter
☐ Double-up/friends/relative due to financial reasons
☐ Unsheltered
☐ Motel/Hotel

Please check child care or education experiences prior to kindergarten:

☐ Home/Informal Care
☐ Head Start
☐ Child Care Center
☐ Nonpublic Nursery School
☐ Prekindergarten
☐ Family Child Care

Additional Care/Educational Services:

☐ Parents As Teachers
☐ Preschool Special Education
☐ Local Infant & Toddlers Program
☐ Judy Center
☐ Home Care by Relative

Responsible Adults at Child's Address:

_____ Relationship to Child _____

Last First Middle

Employer _____ Work Phone No. _____

Driver's License No.: _____ Cell Phone No. _____

Are you joining us as part of the **BRAC** initiative at Aberdeen Proving Ground? **YES** or **NO**

Are you a federal employee? **YES** or **NO**

_____ Relationship to Child _____

Last First Middle

Employer _____ Work Phone No. _____

Driver's License No.: _____ Cell Phone No. _____

Are you joining us as part of the **BRAC** initiative at Aberdeen Proving Ground? **YES** or **NO**

Are you a Federal Employee? **YES** or **NO**

-over-

Brothers and Sisters:

Name	Date of Birth

Persons other than parents to be contacted in case of an emergency during the school day and who are permitted to take the student home (list in priority order):

	Name	Relationship to Child	Phone Number
1.			
2.			
3.			

Doctor's Name: _____ **Phone No.** _____

SPECIAL INSTRUCTIONS CONCERNING THIS CHILD:

Are there any existing court orders regarding custody? If YES, please attach a copy.
YES ☐ NO ☐

Does this child have a 504 plan? If YES, please attach copy.
YES ☐ NO ☐

Does this child have an IEP? If YES, please attach copy.
YES ☐ NO ☐

Has this child ever attended a school in Cecil County? **YES ☐** **NO ☐**
Has this child ever attended a school in any other county in Maryland? **YES ☐** **NO ☐**
Has this child ever attended a school outside of Maryland? **YES ☐** **NO ☐**

If YES, where? _____
Name of School

_____
Address of School City State Zip

Will your child be riding a bus from a location other than your home? **Yes ☐** **No ☐**

If YES, please indicate the address:
Name _____
Address _____
Telephone Number _____

Proof of residence must be provided before the student enrollment is complete. Please attach acceptable proof to the back of this sheet.

- ☐ Current Property Tax Bill
- ☐ Current Rental Lease Agreement
- ☐ Current Utility Bill with Applicant's Name and Address
- ☐ Settlement Papers
- ☐ Deed
- ☐ Documentation of Residency with the appropriate information for verification
- ☐ ACP Card (*Address Confidentiality Program*)

Student ID # _____ *School Use Only* Teacher _____
Enrollment Date _____ Grade _____

CECIL COUNTY PUBLIC SCHOOLS EMERGENCY INFORMATION CARD
SCHOOL YEAR _____

IT IS THE PARENT'S/GUARDIAN'S RESPONSIBILITY TO KEEP THIS INFORMATION CURRENT.

NEW ENTRANT STUDENT DATA

Student's Legal Name: _____
Last Name First Name Middle Name

Other Name: (Name other than legal name by which the student is known – DO NOT LIST NICKNAMES _____

Date of Birth: _____ **Student's School Bus Number** _____

Student's Primary Phone Number(s): _____

Student's Home Address: _____
Street City State Zip

Mailing Address (if different from Home Address): _____
P.O.Box City State Zip

Day Care Provider's Name: _____

Day Care Provider's Address: _____

Day Care Provider's Phone Number(s): _____

Brothers and Sisters:	**Name**	**Date of Birth**

RESPONSIBLE PARENT/GUARDIAN CONTACT INFORMATION

Is there an existing court order regarding CUSTODY for the above-mentioned student?
Yes ☐ No ☐ If yes, have you submitted a copy to the school? Yes ☐ No ☐

Name of Parent/Legal Guardian with whom the student lives:

1 _____ Relationship to child _____
Parent/Guardian Primary Phone #_____ Secondary phone number _____
Employer _____ Work phone number _____

2 _____ Relationship to child _____
Parent/Guardian Primary Phone #_____ Secondary phone number _____
Employer _____ Work phone number _____

List persons—other than the parent/guardian listed above, that should be contacted in case of an emergency during the school day and who are permitted to take the student home (list in priority order).

	Name	*Relationship to Student*	*Phone Number*
3			
4			
5			
6			

HEALTH/MEDICAL INFORMATION

This information will be shared with school teachers, staff, or emergency personnel when we feel it is necessary.

Doctor's Name _____ Doctor's Phone Number _____
Dentist's Name _____ Dentist's Phone Number _____
Allergies (food, bee sting, medication, etc.) _____
Current medications taken at home and at school _____
Medical condition diagnosed by a doctor _____
Does your student have health insurance? Yes ☐ No ☐

Parent/Guardian Signature _____ Date_____

Cecil County Public Schools

HOME LANGUAGE SURVEY

Date _____ School _____ Grade _____

Child's Name _____
First Name Middle Initial Last Name

Parent or Guardian's Name _____
First Name Middle Initial Last Name

Address _____
Street City State Zip

Phone Number _____
Home Work

1. Child's date of birth: _____ (Month/Date/Year)
   Was your child born in the United States? ❑ Yes ❑ No
   If yes, in which state? _____
   If no, in what other country? _____
   If no, date child entered the United States: _____ (Month/Date/Year)

2. Has your child attended any school in the United States for any three years during their lifetime? ❑ Yes ❑ No
   If yes, please provide school name(s), state, and dates attended:
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____

3. What is the language most frequently spoken at home? _____

4. If available, in what language would you prefer to receive communication from the school? _____

5. Please check if your child is:
   A. ❑ Native American Indian
   B. ❑ Alaska Native
   C. ❑ Native Pacific Islander
   D. ❑ Native U.S. Virgin Islander

6. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

If you responded "Yes" to question number 6 above, please answer the following questions:

7. In what country did your child most recently reside? _____

8. Which language did your child learn when he/she first began to talk? _____

9. What language does your child most frequently speak at home? _____

10. What language do you most frequently speak to your child? (Father) _____
    (Mother) _____

11. Please describe the language <u>understood by your child</u>. (Check only one)
    A. ❑ Understands only the home language and no English.
    B. ❑ Understands mostly the home language and some English.
    C. ❑ Understands the home language and English equally.
    D. ❑ Understands mostly English and some of the home language.
    E. ❑ Understands only English.

_____ _____
Parent or Guardian's Signature Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

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: _____

Cecil County Public Schools
Elkton, Maryland 21921

STUDENT HEALTH HISTORY UPDATE

This information will be shared with administration and staff on a "need to know" basis.
It will also be shared with EMS personnel in the event of an emergency.

Name of Student _____ DOB _____ Grade _____

PLEASE CHECK BOX IF STUDENT HAS HAD ANY OF THE FOLLOWING HEALTH CONCERNS

O ADD / ADHD	O Body Piercing/Tattoo	O Emotional Issue	O Physical Disability
O Allergies	O Bone/Joint Problem	O Hearing Problem	O Seizures
O Asthma	O Bowel/Bladder Problem	O Heart Problem	O Speech Problems
O Behavior Problems	O Chicken Pox	O Infections	O Surgery
O Bleeding	O Diabetes	O Kidney Problems	O Vision Problem
O Other (Please explain)			
Comments:			

Does your student have allergies to:

- O Medication (please list) _____
- O Food (please list) _____
- O Insect stings (please list type of insect) _____
- O Latex

Since school ended in June, has your student had any of the following:

- O Illness (please list)
- O Surgery (type of operation)
- O Treated or evaluated for a medical / health condition (please list)
- O Immunizations (please provide doctor documentation)

Is this student currently taking any medications at home or at school? (please list below)

Home	School
1	1
2	2
3	3
4	4

Does this student need any assistive devices? (crutches, walker, wheelchair, hearing aid,etc.) _____

Has this student ever seen an eye doctor?

Name of doctor _____ Date of last visit _____
Were glasses prescribed? O YES O NO

Has this student had an emotional upset (recent move, death, separation, divorce) since school ended?

O YES O NO please list _____

What is the name of this student's dentist? _____ **Date of last exam?** _____

What is the name of this student's doctor? _____ **Date of last exam?** _____

Does this student have health insurance? O YES O NO Dental insurance? O YES O NO

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) 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. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237

Baltimore Co. (Cont.)
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727

Frederick . (Cont)
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787

Montgomery (Cont)
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate http://www.fha.state.md.us/och/html/lead.html

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: _____

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 DHMH 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 DHMH COMAR 10.06.04.03 are available at www.dhmh.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.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

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
Head			
Eyes			
ENT			
Dental			
Respiratory			
Cardiac			
GI			
GU			
Musculoskeletal/orthopedic			
Neurological			
Skin			
Endocrine			
Psychosocial			

Health Area of Concern	YES	NO
Attention Deficit/Hyperactivity		
Behavior/Adjustment		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Mobility		
Nutrition		
Physical Illness/Impairment		
Psychosocial		
Speech/Language		
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