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:

9 no evident problem that may affect learning or full school participation *9* problems noted above

_____

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	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 _____ / _____ / _____
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: _____

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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: _____

Baltimore City Health Department

School Health Information Form 20 - 20

This questionnaire is designed to aid school health staff in anticipating health concerns that may affect your child's safety or learning

(*PLEASE PRINT*) School #:_____ Grade/Class: _____

Student Name: _____ Birth Date: _____ ☐ Male ☐ Female

Address: _____ Zip Code: _____

Name of Parent/Guardian: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Home #: _____ Work #: _____ Cell #: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact

1. Name: _____ Relationship: _____
   Phone #: _____ ☐ Home ☐ Work ☐ Cell
2. Name: _____ Relationship: _____
   Phone #: _____ ☐ Home ☐ Work ☐ Cell

MEDICAL

Student's Healthcare Provider/Clinic: _____ Office #: _____

Last Physical (Month/Year): _____

DENTAL

Does your child have a dentist? ☐ Yes ☐ No Last Dental Visit (Month/Year): _____

INSURANCE

Does the student have health insurance? ☐ Medical Assistance/MCHP MA#_____

☐ Private ☐ No Insurance

MEDICAL HISTORY

Have you ever been told by a healthcare professional that your child has *(check all that apply):*

☐ Asthma ☐ Seizure Disorder ☐ Bleeding Disorder ☐ ADD/ADHD ☐ Diabetes ☐ Bone/Muscle Disease ☐ Cancer
☐ Skin Condition ☐ Learning Disability ☐ Heart Condition ☐ Mental Health Condition (ie. depression, anxiety, eating disorder)
☐ Speech/Language ☐ Other_____

Does your child experience any of the following *(check all that apply):*

☐ Nose Bleeds ☐ Frequent Ear Aches or Ear Infections ☐ Overweight for Age ☐ Physical Disability ☐ Fainting Spells
☐ Frequent Headaches ☐ Frequent Stomach Aches ☐ Emotional Concerns ☐ Underweight for Age
☐ Other_____

ALLERGIES

☐ Food ☐ Drugs ☐ Animals ☐ Bees/Wasps ☐ Latex ☐ Molds ☐ Plants ☐ Environmental (dust, smoke, odors, etc.)
Please describe the allergic reaction and the treatment: _____

MEDICATION

Does your child take any medication? ☐ Yes Medication Names: _____ ☐ No

If medication is needed during the school day, please contact the School Health Staff for necessary authorization forms.

HEARING AND VISION

Do you have concerns about your child's hearing? ☐ Yes ☐ No Does your child wear hearing aids? ☐ Yes ☐ No
Do you have concerns about your child's vision? ☐ Yes ☐ No Does your child wear glasses or contacts? ☐ Yes ☐ No

Thank you for your cooperation in completing this form. The information you share will help us take better care of your child while he/she is in school.

Parent/Guardian Signature: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO HEALTH SUITE