PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN** **CHILD'S NAME:** _____

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT.

Explanation, if needed, can be given in the space provided for "REMARKS".	YES	NO
1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	____	____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	____	____
Date of last eye examination: ____/____/____ Doctor's Name: _____		
Results: _____		
Does your child wear glasses?	____	____
Contact lenses?	____	____
3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	____	____
Date of last hearing evaluation ____/____/____ Doctor's Name: _____		
Results: _____		
Does your child use a hearing aid?	____	____
4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.)*?	____	____
5. Does your child have any allergies? If YES, please state what kind of allergies:	____	____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:	____	____
(a) Does this condition require any special health care in the child care facility?	____	____
(b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?	____	____
(c) Does your child require any special adaptations or adaptive equipment?	____	____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	____	____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	____	____

REMARKS (*Provide further explanation for all "YES" answers):* _____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____

Signature of Parent/Guardian **Date**

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER** **CHILD'S NAME:** _____

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ____ Positive ____ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)

a. Vision problem	YES	NO	_____
b. Hearing problem	YES	NO	_____
c. Speech or language problem	YES	NO	_____
d. Other physical illness or impairment	YES	NO	_____
e. Mental, emotional or behavior problems	YES	NO	_____
f. Developmental delays	YES	NO	_____
g. Allergies	YES	NO	_____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school. YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO

If YES, please specify: _____

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs? _____

8. Does this child's physical activity need to be restricted? YES NO

If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO

If YES, please specify type: _____

Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types Enter: Month/Day/Year for each immunization administered												
Dose #	**DTP-DTAP**	**Polio**	**HIB**	**Hep B**	**PCV7**	**MMR**	**Varicella**	**Rotavirus**	**MCV4**	**HPV**	**Hep A**	**Other**
1												
2												
3												
4												
5												