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](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](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](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](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

<table>
<thead>
<tr>
<th>Student’s Name (Last, First, Middle)</th>
<th>Birthdate (Mo. Day Yr.)</th>
<th>Sex (M/F)</th>
<th>Name of School</th>
<th>Grade</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Number, Street, City, State, Zip)</th>
<th>Phone No.</th>
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<table>
<thead>
<tr>
<th>Parent/Guardian Names</th>
<th>Phone No.</th>
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<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Where do you usually take your child for routine medical care?</th>
<th>Phone No.</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Address:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>When was the last time your child had a physical exam?</th>
<th>Phone No.</th>
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<tbody>
<tr>
<td>Month</td>
<td>Year</td>
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</table>

<table>
<thead>
<tr>
<th>Where do you usually take your child for dental care?</th>
<th>Phone No.</th>
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<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
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</tbody>
</table>

## ASSESSMENT OF STUDENT HEALTH

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

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</thead>
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<tr>
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</table>

- 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: ________________

Maryland Schools - Record of Physical Examination  Revised 12/ 04
### PART II - SCHOOL HEALTH ASSESSMENT
To be completed ONLY by Physician/Nurse Practitioner

<table>
<thead>
<tr>
<th>Student's Name (Last, First, Middle)</th>
<th>Birthdate (Mo. Day Yr.)</th>
<th>Sex (M/F)</th>
<th>Name of School</th>
<th>Grade</th>
</tr>
</thead>
</table>

**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?**

<table>
<thead>
<tr>
<th>Physical Exam</th>
<th>WNL</th>
<th>ABNL</th>
<th>Area of Concern</th>
<th>Health Area of Concern</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Head</td>
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<td></td>
<td>Attention Deficit/Hyperactivity</td>
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<tr>
<td>Eyes</td>
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<td></td>
<td>Behavior/Adjustment</td>
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<tr>
<td>ENT</td>
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<td>Lead Exposure/Elevated Lead</td>
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<tr>
<td>GI</td>
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<td></td>
<td>Learning Disabilities/Problems</td>
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<td>GU</td>
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<td>Physical Illness/Impairment</td>
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<td>Speech/Language</td>
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<td>Psychosocial</td>
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<td></td>
<td>Vision</td>
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<tr>
<td>Other</td>
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</table>

**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**

<table>
<thead>
<tr>
<th>Tuberculin Test</th>
<th>Results</th>
<th>Date Taken</th>
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<tbody>
<tr>
<td>Blood Pressure</td>
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<tr>
<td>Height</td>
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</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
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<tr>
<td>BMI %tile</td>
<td></td>
<td>Optional</td>
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<tr>
<td>Lead Test</td>
<td></td>
<td>Optional</td>
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</tbody>
</table>

Maryland Schools - Record of Physical Examination Revised 12/04
(Child’s Name) _______________________________________________ has had a complete physical examination and has

9 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
---|---|---|---

Maryland Schools - Record of Physical Examination Revised 12/04
# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD'S ADDRESS</td>
<td>LAST</td>
<td>FIRST</td>
<td>MIDDLE</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
</tr>
<tr>
<td>SEX: ☐ MALE ☐ FEMALE</td>
<td>BIRTHDATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COUNTY</td>
<td>SCHOOL</td>
<td>GRADE</td>
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</tr>
<tr>
<td>PARENT</td>
<td>OR</td>
<td>LAST</td>
<td>FIRST</td>
</tr>
<tr>
<td>OR</td>
<td>GUARDIAN</td>
<td>ADDRESS</td>
<td>CITY</td>
</tr>
</tbody>
</table>

## CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.

2. Beginning not later than September 2003, the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child’s school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.

3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child’s health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.

4. 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.

## RECORD OF BLOOD LEAD TESTING

<table>
<thead>
<tr>
<th>Test #1</th>
<th>Test #2</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Health Care Provider or Designee OR School Health Professional or Designee</td>
<td>Date</td>
</tr>
</tbody>
</table>

## RECORD OF BLOOD LEAD TESTING EXEMPTION

I, ___________________________ certify that my child does not AND has never resided in an at-risk area.

Parent or Guardian (Print)

<table>
<thead>
<tr>
<th>Signature</th>
<th>Parent or Guardian</th>
<th>Date</th>
</tr>
</thead>
</table>

## RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed ___________________________ / ___________________________ Date

2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed ___________________________ / ___________________________ Date

DHMH #4620 Revised May 2004  Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health
410.767.6713
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

<table>
<thead>
<tr>
<th>Allegany</th>
<th>Baltimore Co. (Cont.)</th>
<th>Frederick (Cont)</th>
<th>Montgomery (Cont)</th>
<th>Queen Anne’s</th>
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</thead>
<tbody>
<tr>
<td>ALL</td>
<td>21239</td>
<td>21757</td>
<td>20812</td>
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Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate

http://www.fha.state.md.us/och/html/lead.html