Maryland
STATE DEPARTMENT OF EDUCATION

Maryland
DEPARTMENT OF HEALTH

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.
https://2019-dsd.maryland.gov/regulations/Pages/13A.05.05.07.aspx
- **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: https://health.maryland.gov/phpa/OIDEOR/IMMUN/Shared%20Documents/MDH_896_form.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 Maryland Department of Health 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:
https://health.maryland.gov/phpa/OEHFP/Documents/MDH%20Blood%20Lead%20Testing%20Certificate%202023.fillable.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 family's 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://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/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 1 Health Assessment

To be completed by parent or guardian

Student's Name (Last, First, Middle) ______________________ Birthdate (MM/DD/YY) __________ Gender __________ Grade ______

Name of School ______________________________ Phone __________

Address (Number, Street, City, State, Zip) ______________________________

Parent / Guardian Names ______________________________

Where do you usually take your child for routine medical care? Phone __________

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 __________

Name ______________________ Address ______________________

Assessment of Student Health

To the best of your knowledge, has your child has any problem with the following? Please check and provide comments if yes.

Student Health Issues	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			
Hospitalizations (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			

Part 1 Health Assessment - continued

To be completed by parent or guardian

Does your child take any medication?

No Yes Name(s) of Medications ____________________

No Yes Treatment ____________________, etc.

Does your child require any special procedure(s) (catheterization, etc.)?

No Yes Specify ____________________

____________________ ____________________

Parent / Guardian Signature Date

Part II – School Health Assessment

To be completed ONLY by Physician / Nurse Practitioner

Student's Name (Last, First, Middle) ______________________ Birthdate (MM/DD/YY) __________ Gender __________ Grade ______

Name of School ____

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?

   No Yes ____

   ____

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		
Muscoskeletal/ Orthopedic				Nutrition		
Neurological				Physical Illness / Impairment		
Skin				Psychosocial		
Endocrine				Speech / Language		
Psychosocial				Vision		
Other				Other		

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.

Part II – School Health Assessment - continued

To be completed ONLY by Physician / Nurse Practitioner

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). http://test.msde.maryland.gov/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

   No Yes ____

   ____

7. Screenings

Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	
Hearing		
Vision		

(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

____ ____________________

Physician / Nurse Practitioner (Signature) Date

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: ____________________
MM/DD/YYYY

PARENT/GUARDIAN NAME: ______________________________ PHONE NO.: ________________

ADDRESS: __________________________________ CITY: ____________________ ZIP: ________

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. ______________________ ______________
Name Title

______________________ ______________
Signature Date

2. ______________________ ______________
Name Title

______________________ ______________
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?

Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?

Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?

Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?

Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?

Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?

Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. ____________
Provider Initial

Parent/Guardian: 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 and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

______________________________________ ________________
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (μg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 μg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention: https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: ____
LAST FIRST MI

STUDENT/SELF ADDRESS: ______________________ CITY: ______________ ZIP: ________

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: ______/______/______

COUNTY: ______________________ SCHOOL: ______________________ GRADE: ______

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: ______________________________ PHONE #: ______________

#	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														
2														
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB 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 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)

School: St. Ursula School

Phone: 410-665-3533 **Fax:** 410-661-1620

POLICY FOR OVER-THE-COUNTER MEDICATION IN SCHOOL

Over-the-counter medications listed on the Consent for Administration of Over-the-Counter Medications Form will be dispensed only if BOTH the medical provider and the parent/ guardian sign and date the form. We will not dispense over-the-counter medication without the signed consent on file. If you do not wish for your child to receive over-the-counter medication at school, please sign the form and check the box indicating, "I do not wish my child to receive any over-the-counter medications at school." A medical provider does NOT need to sign the form if over the-counter-medication will not be given.

If your child is to receive any over-the-counter medication that is not listed on the Consent for Administration of Over-the-Counter Medications Form, please complete The MARYLAND STATE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM, available at https://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationfo rm404.pdf.

Parents/guardians must hand-deliver any over-the-counter medications directly to the School Nurse. Over-the-counter medication must be brought to school in an original, unopened container and labeled with the student's name and homeroom. Students are not permitted to self-carry over-the-counter medications.

If you have any questions, please contact the school nurse.

Thank you!

School: St.Ursula School

Phone: 410-665-3533 Fax: 410-661-1620

CONSENT FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS for School Year 2024-2025
(Must be renewed each year.)

Student's Name: ______________________ Grade: ______ Date of Birth: ______________

Weight: ______ lbs. ______ kg (if needed for dosage) Allergies: ______________________

Medication currently receiving:

____

****Parents/guardians must provide medication to School Nurse in the original, unopened container labeled with their student's name and homeroom. All medications must be hand delivered to the School Nurse by an adult, not sent in with student.****

Check all medications that may be given and specify dose and frequency in the chart below. If you prefer that no over-the-counter medications be administered to your child at school, please check the box below.

	Medication	Reason	Dose	Route	Frequency	Side Effects
□	**Ibuprofen/ Motrin**					
□	**Acetaminophen/ Tylenol**					
□	**Diphenhydramine/Benadryl**					
□	**Antacid Tablets/ Tums**					
□	**Cough Drops**					
□	**Antibiotic Ointment**					
□	**Anti-itch Lotion/Cream (Hydrocortisone, Calamine)**					
□	**Aquaphor, Eucerin**					

Note any special instructions for medications to be given (e.g. take with food): ______________________

____

Please note **School policy does not permit the student to self-carry the over-the-counter medications.**

□ I do not wish my child to receive any over-the-counter medications at school. (No Doctor's Signature is required.)

Parent/Guardian Signature: ______________________ **Date:** ________ **Phone:** ______________

Doctor's Signature: ______________________ **Date:** ________ **Phone:** ______________

School Nurse Signature: ______________________ **Date:** ________ **Phone:** ______________

Baltimore County Public Schools

Baltimore County Department of Health

School Dental Health Record

Name of Student: ______________________ Age:______________

Name of School: ______________________ Grade: ______________

All students can achieve a healthy mouth, provided they practice protective health habits from childhood and have the opportunity to benefit from present-day knowledge of dental disease prevention and control. If your child has not visited your family dentist within the last six months, we advise you make an appointment immediately. After the dental appointment, the signed form should be returned to the school your child will be attending.

A Dental Visit (with a completed signed form) is required when your child enters either:

A PreK Program

Kindergarten

Grade 3

Grade 5

Or is transferring from another school

Report of Dental Examination:

A. ______ No Dental Treatment Is Necessary.
B. ______ All Necessary Dental Treatment Has Been Completed.
C. ______ Treatment Is In Progress.

Further Recommendations

____

____

____

______________________ ______________________

Signature of Dentist Date