

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

Maryland Schools Record of Physical Examination

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		
Musculoskeletal/ 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/\\$SSP/SHS/medforms/medicationform404.pdf](http://test.msde.maryland.gov/about/Documents/DSFSS/$SSP/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

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 ($\mu\text{g/dL}$). 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 $\geq 3.5 \mu\text{g/dL}$, 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/phhp/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 #: _____

#	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													
4									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

- Signature _____ Title _____ Date _____
(Medical provider, local health department official, school official, or child care provider only)
- Signature _____ Title _____ Date _____
- Signature _____ Title _____ Date _____

Clinic / Office Name
Office Address/ Phone Number

Lines 2 and 3 are for certification of vaccines given after the initial signature.

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)

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