BALTIMORE COUNTY DEPARTMENT OF HEALTH
Division of School Health Services

HEALTH INVENTORY

To Parents or Guardians:

A physical examination is recommended for all children prior to entrance into school and again upon entrance into Middle School. An Examination is also requested for all children transferring into a school.

To do the best possible job of teaching your child, his or her teachers shoul understand and be aware of special health and developmental needs. This requires some information from you and from the child's physician.

The health information provided on this form will be available only to those health and school personnel who have legitimate educational interest in your child.

Maryland law requires all school students in nursery through twelfth grade to show evidence of complete primary immunizations against certain childhood communicable diseases. Exemptions from immunization requirements are permitted only if a parent objects to immunization because of bona fide religious beliefs and practices. A Maryland Immunization Certificate Form (DHMH 896) must be completed along with the required immunizations before a student can attend school.

Please complete this Health Inventory form and return it to your child's school as quickly as possible.

You are asked to complete Part I of this Health Inventory Form. Part II is t be completed by the physician or nurse practitioner who examines your child.

PART I - HEALTH ASSESSMENT

-To be completed by parent/guardian-

Student Name (Last, First, Middle)	Birthdate (Mo/Day/Yr)	Sex (M/F)	School	Grade

Address (Number, Street, City, State, Zip) Phone No:

Parent/Guardian Names:

Where do you usually take your child for 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, does your child have a history of or any problems with the following. Please check "yes" or "no."

	Yes	No	Comments
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problems or Deafness			
Speech Problems			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			Please list:
Behavior or Emotional Problem			Please list:
Allergies (Food, Insects, Drugs, Etc.)			
Asthma			Please describe severity:
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder or Bowels			
Chicken Pox			If yes, Month & Year:

Does your student take any medication: ☐ Yes ☐ No Name of Medication _____

Parent/Guardian Signature _____ Date _____

PART II - HEALTH ASSESSMENT
-To be completed by Physician/Nurse Practitioner-

Student Name (Last, First, Middle)	Birthdate (Mo/Day/Yr)	Sex (M/F)	School	Grade

Address (Number, Street, City, State, Zip) Phone No:

1. 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?) If yes, please DESCRIBE.

☐ No ☐ Yes _____

_____

2. Is the child on long-term technology assistance? Please note specifics.

☐ No ☐ Yes _____

_____

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing an "X" in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/Impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			

REMARKS: (Please explain any "yes"; include recommendations for referral and treatment.)

_____

_____

4. RECORD OF IMMUNIZATIONS-If possible, record all the child's doses with dates on the DHMH 896, MARYLAND IMMUNIZATION -- CERTIFICATE form. This section is only to be used if the DHMH 896 is not available.

RECORD OF IMMUNIZATION

DOSE No.	VACCINE TYPE								
	DTP-DTAP DT-TD MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	M-M-R MO/DAY/YR	VARICELLA MO/DAY/YR	PREVNAR MO DAY/YR	OTHER MO/DAY/YR	OTHER MO/DAY/YR
1									
2									
3									
4									
5									

*Blood Test verification of immunity and date may be entered in lieu of vaccination date.

PHYSICIAN
HEALTH OFFICIAL
SCHOOL OFFICIAL
OR DAY CARE PROVIDER

TO THE BEST OF MY KNOWLEDGE THE VACCINES LISTED ABOVE WERE ADMINISTERED AS INDICATED

Signed _____
(Parent Signature not Valid)

Title _____

Date _____

5. Is the student on long-term medication? If yes, please DESCRIBE.

☐ No ☐ Yes _____

(A medication administration form must be completed for in-school administration.)

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

☐ No ☐ Yes _____

7. Blood Pressure	Height	Weight	Date Taken

If you would like to discuss this student's health with school or school health personnel, check title below.

☐ Nurse assigned to school ☐ Teacher(s) ☐ Counselor ☐ Principal ☐ School Health Physician

(Student Name)_____ has had a complete physical examination and has

☐ no evident problem that may affect learning or ☐ problems noted above

Physician/Nurse Practitioner (Type/Print)	Phone No.	Physician/Nurse Practitioner (Signature)	Date

Additional Comments: