EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
   Last First

   Address _____
   Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address *(If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address *(If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____

Name of Health Practitioner Date

_____ (____)_____

Signature of Health Practitioner Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____ _____
Last **First** **Middle** **Birth Date**

Name of Parent or Guardian _____ _____
Relationship

Home Address _____

City _____ **State** _____ **Zip Code** _____

Check Best Telephone Number to Reach You:

☐ **Home #:** _____ ☐ **Work #:** _____ ☐ **Cell #:** _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

_____
City/Town **State** **Zip Code**

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												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a ☐ permanent ☐ temporary condition until ____/____/____. Check appropriate box, indicate vaccine(s) and reasons: _____

_____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care.
(circle correct response)

Signature of Health Practitioner	**Date**	**Phone Number**

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. **If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE	Baltimore (cont)	Carroll	Frederick(cont)	Montgomery	Prince George's(cont)	St. Mary's
	21210	21155	21783	20783	20782	20606
	21212	21757	21787	20787	20783	20626
	21215	21776	21791	20812	20784	20628
Allegany	21219	21787	21798	20815	20785	20674
ALL	21220	21791		20816	20787	20687
	21221		**Garrett**	20818	20788	
Anne Arundel	21222	**Cecil**	ALL	20838	20790	**Talbot**
20711	21224	21913		20842	20791	21612
20714	21227		**Harford**	20868	20792	21654
20764	21228	**Charles**	21001	20877	20799	21657
20779	21229	20640	21010	20901	20912	21665
21060	21234	20658	21034	20910	20913	21671
21061	21236	20662	21040	20912		21673
21225	21237		21078	20913		21676
21226	21239	**Dorchester**	21082		**Queen Anne's**	
21402	21244	ALL	21085	**Prince George's**	21607	**Washington**
Baltimore	21250		21130	20703	21617	ALL
21027	21251	**Frederick**	21111	20710	21620	
21052	21282	20842	21160	20712	21623	**Wicomico**
21071	21286	21701	21161	20722	21628	ALL
21082		21703		20731	21640	
21085	**Baltimore City**	21704	**Howard**	20737	21644	**Worcester**
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	**Calvert**	21719	**Kent**	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204		21758	21645	20746		
21206	**Caroline**	21762	21650	20748	**Somerset**	
21207	ALL	21769	21651	20752	ALL	
21208		21776	21661	20770		
21209		21778	21667	20781		
		21780				

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICATION AUTHORIZATION FORM

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions with prior written permission (Section A) from the child's parent/guardian. A separate form is needed for each prescription or non-prescription medication to be administered to the child.

PRESCRIPTION MEDICATIONS AND NON-PRESCRIPTION MEDICATIONS: Prescription medications must be in a container labeled by the pharmacy or physician with the child's name, dosage, and expiration date. At least one dose of prescription medication must be given at home prior to the child's arrival at the child care facility. **Non-prescription** medications must be in the original manufacturer's container labeled with instructions for dosage and expiration date. Except for acetaminophen (Tylenol) and other topical medications, a provider may administer only one dose of non-prescription medication to a child per illness unless a licensed health practitioner provides written approval (Section B) for the administration of the non-prescription medication and the dosage. All medication shall be administered according to the instructions on the label of the medication container or a licensed health practitioner's written instructions, whichever are more recently dated. **An adult should bring the medication to the center/provider.**

Name of Child: _____ **Date of Birth:** _____ **Age:** _____

SECTION A: (To be completed by parent/guardian for any medication to be administered to the child.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
I/We request that designated child care providers/or staff administer medication as noted on this form. I/We certify that I/We have legal authority to consent to medical treatment for the child named above, including administration of medication while in child care. I/We understand that at the end of the year or if the medication is discontinued or expired, an adult must pick up the medication, otherwise it will be discarded. **Signature of Parent/Guardian:** _____ **Date:** _____				

SECTION B: (To be completed by the Health Practitioner for approval to administer non-prescription medication more than one dose per illness, other than acetaminophen (Tylenol) or other topical medication.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
ADDITIONAL INSTRUCTIONS:				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
Health Practitioner's Signature:			**Date:**	
Print, Type or Stamp: Name, Address, Phone number and Title of Health Practitioner:				

MEDICATION ADMINISTERED

Except for the application of a non-prescription diaper rash treatment, sunscreen, or insect repellent supplied by the child's parent, each administration of a medication to the child shall be noted in the child's record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:				**Date of Birth:**
Medication:				
DATE	**TIME**	**DOSAGE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**