

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 should 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 to 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? Name:			Phone No:	
			Address:	
When was the last time your child had a physical exam:		Month:	Year:	
Where do you usually take your child for dental care: Name:			Phone No:	
			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: <input type="checkbox"/> Yes <input type="checkbox"/> 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
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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	CONCERN			Health Area	CONCERN		
	Yes	No	Not Evaluated		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	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 _____
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