

**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.***
<http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm>

- ***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:***
<http://www.edcp.org/pdf/DHMH896new.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 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:***
<http://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.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 families 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://www.marylandpublicschools.org/NR/rdonlyres/8D9E900E-13A9-4700-9AA8-5529C5F4C749/3341/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
Records Retention - This form must be retained in the school record until the student is age 21.

Maryland State Department of Education

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

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
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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?
 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		

REMARKS: (Please explain any abnormal findings.)

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.

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).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
 No Yes _____

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed **ONLY** by Physician/Nurse Practitioner

(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 No.

Physician/Nurse Practitioner Signature

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 DHMH 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 DHMH COMAR 10.06.04.03 are available at www.dhmh.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.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

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 to make an appointment immediately. After the dental appointment, the signed form should be returned to the school your child will be attending.

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: _____

Date

Signature of Dentist

PARENT'S REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Dear Parent/Legal Guardian:

To request medication administration at school, please note:
This form must be completed and signed by you and your child's medical provider.

- A new form is needed for all changes in medication, dose, or time.
- The medication should be brought to school by a parent/guardian or responsible adult.
- The medication container must be labeled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
- Unless otherwise specified, medication order is valid for the entire school year.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Special/Emergency Instructions: _____

Prescriber's Name/Title: _____ Telephone: _____

Address: _____ Fax: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. (I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.) I/We authorize the school nurse to communicate with the health care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINES WILL APPLY UNLESS YOU INDICATE OTHERWISE IN WRITING :

- One hour late opening: doses will be given as usual, with minor modifications in timing, if needed.
- Two hour late opening: medications scheduled to be given before 10 a.m. will not be given in school; other doses will be given according to the prescribed schedule.
- Three hour early dismissal: medications scheduled to be given at lunchtime or later will not be given.

AUTHORIZATION FOR STUDENT TO CARRY EPINEPHRINE AUTO-INJECTOR AND/OR INHALER

Prescriber Authorization _____

Signature

Date

Parent/Guardian Authorization _____

Signature

Date

TO BE COMPLETED BY SCHOOL

Date form received at school : _____ Received by: _____