MEDICAL FORM

PART I - To be completed by **PARENT** The health information contained herein is for **CONFIDENTIAL USE ONLY**.

Child's Name_____ Birth Date _____
Last First Middle

Parent/Guardian_____Relationship _____

Home Address _____Home Telephone_____
Street City Zip

	Yes	No
1. Are there concerns regarding eating, sleeping habits, posture, teeth, weight, etc. about your child's general health? (if yes, explain below)	___	___
2. Does your child have any eye problems? (Difficulty seeing, crossed eyes, reddened or watery eyes.)	___	___
3. Does your child wear glasses?	___	___
4. Does your child have any ear or hearing problems? (frequent ear aches, difficulty hearing, tubes, etc.)	___	___
a. Does your child use a hearing aid?	___	___
5. Does your child have any speech problems? (difficulty having speech understood, stammering, delayed level.)	___	___
6. Does your child have any other specific illness or disability which might, in your opinion, affect his school performance?	___	___
a. Has your child received a medical or other evaluation, the findings of which could help school personnel meet his health/educational needs?	___	___
b. Does this problem require any special care at school?	___	___
7. Do you have any concerns about your child's behavior or emotional well-being of which the school should be aware?	___	___

REMARKS (Clarify any "Yes" answers below or attach separate sheet if necessary)

I GIVE MY PERMISSION FOR THE PHYSICIAN TO COMPLETE **PART II** FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND/OR EDUCATIONAL NEEDS IN SCHOOL.

Parent Signature _____ Date _____

PART II: MEDICAL EVALUATION - TO BE COMPLETED BY PHYSICIAN

_____ has had a complete history and physical examination at my office on ____/____/____. Findings for this child are indicated as follows:

1. Date of most recent tuberculin test ____/____/____.

Result: _____ Positive _____ Negative

Please check all that apply:

2. _____ The child has the following which may adversely affect his education/care experience:

   a. Visual problem _____
   b. Hearing problem _____
   c. Speech or language problem _____
   d. Other physical illness or impairment _____
   e. Mental, emotional or behavior problem _____

Significant physical findings, comments, and recommendations: _____

_____

_____

_____

3. _____ The child has a health condition which may require emergency action while he is at school. (Please specify, e.g., seizures, bee sting allergy, diabetes, etc.): ____

_____

Recommendations: _____

_____

4. _____ The child is on long term medication.

   Please specify: _____
   (If emergency medication is to be administered during the hours a child is in school, i.e., an Epi-Pen or inhaler, the Physician must complete and sign an *Authorization to Administer Medication* form)

5. _____ Except as noted above, the child is otherwise in good physical and mental health, is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

_____ _____

Physician Print Name | Office Phone

_____ _____

Signature of Physician | Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

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

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

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 immunizations 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 directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per 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; and (h) Varicella."

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.EDCP.org (Immunization).

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.EDCP.org (Immunization).