

**PART II - CHILD HEALTH ASSESSMENT**  
To be completed *ONLY* by Health Care Provider

<b>Child's Name:</b>			<b>Birth Date:</b>			<b>Sex</b>																																																																																																																																																	
Last	First	Middle	Month / Day / Year			M <input type="checkbox"/>	F <input type="checkbox"/>																																																																																																																																																
<p>1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?  <input type="checkbox"/> No    <input type="checkbox"/> Yes, describe:</p>																																																																																																																																																							
<p>2. Does the child receive care from a Health Care Specialist/Consultant?  <input type="checkbox"/> No    <input type="checkbox"/> Yes, describe</p>																																																																																																																																																							
<p>3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.  <input type="checkbox"/> No    <input type="checkbox"/> Yes, describe:</p>																																																																																																																																																							
<p>4. Health Assessment Findings</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Physical Exam</th> <th style="width:8%;">WNL</th> <th style="width:8%;">ABNL</th> <th style="width:8%;">Not Evaluated</th> <th style="width:25%;">Health Area of Concern</th> <th style="width:8%;">NO</th> <th style="width:8%;">YES</th> <th style="width:18%;">DESCRIBE</th> </tr> </thead> <tbody> <tr><td>Head</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td><td>Allergies</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td><td></td></tr> <tr><td>Eyes</td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td><td align="center"><input type="checkbox"/></td><td>Asthma</td><td align="center"><input type="checkbox"/></td><td align="center"><input 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<p>6. Is the child on medication?  <input type="checkbox"/> No    <input type="checkbox"/> Yes, indicate medication and diagnosis:  <b>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).</b>  <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a></p>																																																																																																																																																							
<p>7. Should there be any restriction of physical activity in child care?  <input type="checkbox"/> No    <input type="checkbox"/> Yes, specify nature and duration of restriction:</p>																																																																																																																																																							
<p>8. Are there any dietary restrictions?  <input type="checkbox"/> No    <input type="checkbox"/> Yes, specify nature and duration of restriction:</p>																																																																																																																																																							
<p>9. <b>RECORD OF IMMUNIZATIONS</b> – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 896.)</p>																																																																																																																																																							
<p>10. <b>RECORD OF LEAD TESTING</b> - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 4620)</p> <p>Under Maryland law, all children younger than 6 years old who are enrolled in child care 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.</p>																																																																																																																																																							

Additional Comments: \_\_\_\_\_

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date: