QUEST
Quality Education for Every Student

STUDENT RECORD CARD
SR-6
(Local)
Revised 9/00

HEALTH INVENTORY

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 either nine months prior to entering the public school system or within six months after entering the system. The physical examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene (SR-6, [Local], Revised 5/30/91) or a comparable health inventory form must be used to document that this requirement has been met.
- Evidence of complete primary immunizations against common childhood communicable diseases is required for all students in nursery through the twelfth grade. A Maryland Immunization Certificate (Form DHMH 896) for newly enrolling students may be obtained from the local health department or from school personnel. This form and the required immunizations must be completed before a child may attend school.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a student's religious beliefs. Students may also be exempted from immunization requirements if a physician or certified nurse practitioner certifies that it would create a medical problem for the student.

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.

In order to assist your child in gaining the most from his/her educational experience, please complete Part I of this Health Inventory form. Part II must be completed by a physician or certified nurse practitioner or attach a copy of your child's physical examination to this form.

If your child requires medication to be administered in school, you must have the physician or certified nurse practitioner complete the medication administration form. This form can be obtained from your child's school. If you do not have access to a physician or certified nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or nurse/health aide in your child's school.

You are asked to complete Part I of this Health Inventory form. Part II is to be completed by the physician or the certified nurse practitioner who examines your child.

Maryland State Department of Education
Maryland State Department of Health and Mental Hygiene
Prince George's County Public Schools

PART I -- STUDENT HEALTH HISTORY

-- To be completed by parent/guardian --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

Address (Number, Street, City, State, Zip)	Phone No.

Parent or Legal Guardian Names

Where do you usually take your child for medical care? Phone No.:

Name: Address:

When was the last time your child had a physical exam?

Month: Year:

Where do you usually take your child for dental care? Phone No.

Name: 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 Problem or Deafness			
Speech Problem			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Allergies, (Food, Insects, Drugs, etc.)			
Behavior or Emotional Problem			
	Yes	**No**	**Comments**
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			

Does your child take any medication(s)? ❑ Yes ❑ No

Name of Medication(s) _____

Parent or Legal Guardian Signature _____ Date _____

PART II -- STUDENT HEALTH ASSESSMENT / PHYSICAL EXAMINATION

-- To be completed by physician or certified nurse practitioner --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

Address (Number, Street, City, State, Zip)	Phone No.

1. Does this child have a health condition which may require EMERGENCY ACTION while he/she is at school: (e.g., seizure, insect sting, asthma, allergy, bleeding problem, diabetes, heart problem?) If yes, please DESCRIBE.

❑ No ❑ Yes _____

2. Is the student on long-term medication? If yes, please DESCRIBE.

❑ No ❑ Yes _____

(A Medication administration form must be completed for in-school administration.)

3. Is this child on long-term technology assistance?

❑ No ❑ Yes _____

(Please note specifics) _____

4. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a 3 in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			
Scoliosis				Other			

REMARKS: (Please explain any "yes"; include recommendation for referral and treatment.)

5. Should there be any restriction of physical activity in school? If so, specify nature and duration of restriction.

❑ No ❑ Yes _____

6. Tuberculin Test: Results	Type	Date of last test	Blood Pressure	Height	Weight	Date Taken
❑ Positive ❑ Negative						

If you would like to discuss this student's health with school or school health personnel, check title below

❑ Nurse assigned to school ❑ Teacher(s) ❑ Counselor ❑ Principal ❑ School Health Physician ❑ Other

(Student Name) _____ has had a complete physical examination and has

❑ no evident problem that may affect learning **OR** ❑ problems noted above.

Physician /Certified Nurse Practitioner (Type of Print)	Phone No.	Physician/Certified Nurse Practitioner (Signature)	Date

-- Additional Comments on Reverse Side --

Additional Comments:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

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This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.