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 no more than nine months before or six months after enrollment. A physical examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene must be used to meet this requirement.
- Evidence of immunizations against common childhood communicable diseases is required for all students in nursery through the twelfth grade. A Maryland Immunization Certification form for newly enrolling students may be obtained from the local Department of Health and Human Services or from school personnel. The form and the required immunizations must be completed before a child may attend school. (Form DHMH 896)

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 certifies that there is a medical contraindication.

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 2 must be completed by a physician or 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 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 nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or nurse in your child's school.

Please complete this Health Inventory form and return it to your child's school as quickly as possible.

Students enrolled in grades 9-12 must have an annual medical evaluation by a physician or nurse practitioner in order to participate in interscholastic athletics.

A letter from a physician or nurse practitioner giving an athlete permission to participate in interscholastic athletics is required when he/she has experienced a significant injury, illness, or surgery since the last medical evaluation.

Complete Part 3 prior to seeing the physician or nurse practitioner if your child will be participating in interscholastic athletics.

FORGERY on any part of this form is a violation of Maryland Public Secondary Schools Athletic Association (MPSSAA) Regulations and will result in the student being declared ineligible for the season and forfeiture of any contest(s) he/she competed in while having a forged medical examination.

PART 1 HEALTH ASSESSMENT
– To be completed by parent/guardian –

_____ ____/____/____ _____ _____
Student Name (Last, First Middle) *Birth Date* *School Name* *Grade*

_____ _____-____-_____
Address (Street, City, State, Zip) *Phone Number*

_____ _____
Parent/Guardian (Male) *Parent/Guardian (Female)*

_____
Physician/Nurse Practitioner Name and Address

_____
Dentist Name and Address

_____
Other source(s) from which the student receives health care. (If none, write "None.')

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know? Please check (✓) "Yes," or "No" for each of the following:

	Yes	No	Comments
Allergies (Drugs, Food, Insects)			describe reaction
Asthma			
Behavior or Emotional Problem			
Birth Defects			
Bladder Problem			
Bleeding Problems			
Bowel Problems			
Cerebral Palsy			
Concussion (Head Injury)			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning			
Limits on Activity			
Medication			
Meningitis			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech Problem			
Surgery			

If you would like to discuss your child's health with school or school health personnel, please check title:
☐ Nurse assigned to school ☐ Teacher ☐ Counselor ☐ Principal

I give my permission for confidential and discreet use of Part 2, the health evaluation completed by the physician/nurse practitioner, to meet my child's health and educational needs in school. (Check (✓) one) ☐ Yes ☐ No

_____ ____/____/____
Signature, Parent/Guardian *Date*

IMPORTANT: Schedule an appointment for a medical examination of your child; share the above information with the physician or nurse practitioner, have him/her complete Part 2 after the examination and then return the form to the school.

PART 2 HEALTH EVALUATION
– To be completed by physician/nurse practitioner –

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

☐ No ☐ Yes _____

_____

2. Is this child on long-term technology assistance? ☐ No ☐ Yes _____

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a check (✓) in the appropriate box.

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	☐	☐	☐

Please explain all yes answers. Include recommendations for referral and treatment.

_____

_____

_____

_____

_____

4. Immunizations given on this visit: ☐ DPT/Td # _____; ☐ Polio # _____; ☐ MMR #_____; ☐ Other _____

5. Tuberculin Test: Results ☐ Positive ☐ Negative _____ _____/_____/_____ _____ _____ ____/____ _____ ____/____/____

Type | Date (most recent) | Height | Weight | BP | Pulse Rate | Date Taken

6. Is the student on long-term medication? If yes, please describe.

☐ No ☐ Yes _____

(MCPS Form *525-13: Authorization to Administer Prescribed Medication* must *be* completed for in-school administration

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

☐ No ☐ Yes _____

_____

8. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below that are **NOT CROSSED OUT?**

☐ No ☐ Yes ☐ Not Applicable

Baseball	Football	Pompons	Track/Field
Basketball	Golf	Soccer	Volleyball
Cheerleading	Gymnastics	Softball	Wrestling (minimum weight)
Cross Country	Indoor Track	Swimming/Diving	Other (specify) _____
Field Hockey	Lacrosse	Tennis	_____

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

☐ Nurse assigned to school ☐ Teacher ☐ Counselor ☐ Principal

Student Name (Type/print) _____ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

_____ ____-____-____ _____ ___/___/___

Physician/Nurse Practitioner (Print) | *Phone Number* | *Original Signature, Physician/Nurse Practitioner* | *Date*

IMPORTANT: Maryland Immunization Certification is required by law. Please complete Form DHMH 896.

PART 3 - INTERSCHOLASTIC ATHLETICS
– To be completed by parent and sports candidate –

Student Name: _____
Last *First* *M*

FOR STUDENTS PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Please check yes or no for each of the following questions. Explain all yes answers in the "Comments" column. Include names and dates where appropriate.

	Yes	No	Comments
Do you know of any reason why this individual should not participate in all sports?			
Has the individual been advised by a physician during the past year to restrict activity?			
Has the student ever had surgery?			
Has the student ever:			
been hospitalized?			
been unconscious?			
fainted?			
had frequent headaches?			
had convulsions?			
had numbness or tingling of face, arms, hands, legs, or feet?			
had chest pain?			
had shortness of breath?			
had enlarged liver or spleen?			
become weak or ill when exposed to high temperatures?			
Has the student ever had:			
head injury?			
neck injury?			
back pain?			
shoulder separation or dislocation?			
ankle sprain?			
knee trouble (including torn cartilage)?			
knee cap dislocation?			
broken bone or fracture?			
pulled ligament or ruptured tendon?			
swollen, dislocated, or painful joint?			
serious muscle injury or rupture?			
Does the student have loss or seriously impaired function of any paired organ?			
eye			
ear			
lung			
kidney			
testicle/ovary			
Does the student wear:			
glasses?			
contact lenses?			
dental braces?			
other:			

Forgery on any part of this form is a violation of Maryland Public Secondary Schools Athletic Association (MPSSAA) Regulations and will result in the student being declared ineligible for the season and forfeiture of any contest(s) he/she competed in while having a forged medical examination.

_____ ____/____/____ _____ ____/____/____
Signature, Parent or Guardian *Date* *Signature, Sports Candidate* *Date*