DHR Department of Human Resources 311 W. Saratoga St. Baltimore, MD 21201	**FIA ACTION TRANSMITTAL** MAY 15 1998
Issuance Date: May 18, 1998	**Effective Date: Immediately**
	Control Number: FIA/OPA #98-47

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
PURCHASE OF CARE ADMINISTRATORS
FAMILY INVESTMENT SUPERVISORS/ELIGIBILITY STAFF

FROM: LINDA HEISNER, EXECUTIVE DIRECTOR, CCA
KEVIN MAHON, EXECUTIVE DIRECTOR, FIA

RE: AVAILABILITY OF HEALTH FORMS FOR REGULATED CHILD CARE AND EDUCATIONAL BROCHURES

PROGRAMS AFFECTED: PURCHASE OF CARE

ORIGINATING OFFICE: OPD / CHILD CARE ADMINISTRATION

SUMMARY:

Federal Regulations under the Child Care & Development Fund require States to provide comprehensive consumer education material to customers to increase the level of understanding about the features and importance of quality regulated child care. In Maryland one method the Child Care Administration uses to comply with this requirement is through the distribution of the educational brochure "Making The Difference For Your Child: Choosing Regulated Care in Maryland." The brochure is available in English and Spanish and provides customers with tips on selecting and locating a regulated provider.

Additionally, a Purchase of Care (POC) workgroup consisting of representatives from local departments of social services, child care providers, advocates and others has been meeting since July to examine POC income guidelines and other programmatic issues. At the last meeting, it was suggested that local departments give out the health forms that a parent will need to enroll a child in regulated child care. The local department representatives and providers that were present at the meeting felt this would be helpful in giving customers time to have the forms completed before enrolling their children.

The Child Care Administration (CCA) conducted surveys of local departments to determine the number of health forms, and brochures needed (English and Spanish). Local departments that choose to place an initial order or to continue to provide these forms and brochures after the initial supply is exhausted may do so by contacting Donna Wiltshire, Chief Administrative Services in CCA. Her number is (410) 767-7799.

ACTION REQUIRED:

1. The following health forms should be given to customers, who choose regulated or licensed care, during the initial interview:

   a. Emergency Card DHR/CCA 1214,
   b. Emergency Care Plan DHR/CCA 1280,
   c. Health Inventory DHR/CCA 1215,
   d. Maryland Immunization Certificate Form,
   e. Lead Paint Screening - Health Inventory Addendum

2. During the initial application for POC case managers should give every POC applicant a copy of "Making the Difference For Your Child: Choosing Regulated Care in Maryland" and note the distribution on the case summary sheet.

EFFECTIVE DATE: Immediately.

Questions may be directed to Pamela Evans at (410) 767-7845 of the Child Care Administration.

cc: Lynda G. Fox
FIA Assistant Directors
POC Administrators

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR
CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND
NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

ADDENDUM

Under Maryland law, a child under six years of age who is admitted to child care must have appropriate screening for lead poisoning. Parents or guardians must submit evidence of this screening to the child care provider within 30 days of admission to care.

To be completed by a HEALTH PRACTITIONER

_____ _____
CHILD'S NAME BIRTH DATE

has received appropriate screening and/or testing for lead poisoning.

_____ _____
Signature of Health Practitioner **Date**

_____ _____
Address **Phone**

_____
City **State** **Zip Code**

_____ _____
Name of Parent or Guardian **Date**

_____ _____
Address **Phone**

_____
City **State** **Zip Code**

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: _____
(Child Care Center, Family Child Care Home, School)

Address: _____
Street

_____
City **State** **Zip Code**

ATTENTION: _____

MARYLAND DEPT. OF HEALTH AND MENTAL HYGIENE — **MARYLAND IMMUNIZATION CERTIFICAT**

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____
MO. DAY YR.

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATION

VACCINE TYPE						VACCINE TYPE				
DOSE #	DTP-DTaP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES* MO/DAY/YR	RUBELLA* MO/DAY/YR	MUMP MO/DAY
1						1				
2						2				
3						DOSE #	Varicella** MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER MO/DAY
4						1				
5						2				

* Blood test verification of immunity and date may be entered in lieu of vaccination date

** Blood test verification of immunity or chickenpox disease date may be entered in lieu of vaccination date.

PHYSICIAN, HEALTH OFFICIAL, SCHOOL OFFICIAL, OR DAY CARE PROVIDER

TO THE BEST OF MY KNOWLEDGE, THE VACCINES LISTED ABOVE WERE ADMINISTERED AS INDICATED.

Signed _____
(Parent signature not valid)

Title _____

Date _____

LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department.)

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 RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.
This is a permanent condition ☐ temporary condition ☐ until _____
MO/DAY/YR

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

Signed _____ Date _____
Physician or Health Official

RELIGIOUS OBJECTION:

to the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization ng given to my child.

Signed _____ Date _____
Parent or Guardian

CERTIFICATION INFORMATION

The following excerpt from the Code of Maryland Regulations (COMAR) 10.06.04 applies to schools.

> A school principal or other person in charge of a school, public or private, may not knowingly admit a student to, or student in 1) preschool program unless the student has furnished evidence of age-appropriate immunity against Haemophilus infl type b 2) preschool program or kindergarten through the second grade of school unless the student has furnished proof appropriate immunity against pertussis; and 3) preschool program through the twelfth grade unless the student has furnished ev of age-appropriate immunity against tetanus, diphtheria, poliomyelitis, measles (rubeola), mumps, and rubella.

Immunization requirements for licensed child care centers (COMAR 07.04.02) and family day care homes (COMAR 07.04.0 based on the Maryland DHMH recommended immunization schedule. (Exception: See notes 11 and 12, below)

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
(Recommended Immunization Schedule)

RECOMMENDED SCHEDULE

Age	Vaccine
Birth	HBV
2 mos.	DTaP, Polio, Hib, HBV
4 mos.	DTaP, Polio, Hib
6 mos.	DTaP, Hib, HBV
12 mos.	MMR #1, Polio, Varicella
15 mos.	Hib, DTaP
4-6 yrs.	Polio, MMR #2, DTaP
12 yrs.	MMR #2, (if not given earlier)

ABBREVIATIONS

DTaP - Diphtheria and tetanus toxoids with acellular pertussis vaccine
Polio - Polio vaccine, oral or injectable
MMR - Measles, mumps, and rubella combined vaccine
Hib - *Haemophilus influenzae* type b vaccine
(Vaccine schedule may vary depending on the manufacturer
HBV - Hepatitis B vaccine
Varicella - Chickenpox vaccine

COMPLIANCE FOR SCHOOL AND DAY CARE ADMISSION

The medical provider that gave the vaccinations may record the dates directly on this form and certify them by signing or stamping the signature section, OR, a dif medical provider, a local health department official, a school official, or a day care provider may transcribe onto this form and certify vaccination dates from any record which has the authentication of a medical provider, health department, school, or day care service.

1. Children 18 months of age and older are required to have 3 doses of Polio to enter school, day care, or preschool programs. At age 4-6, a 4th dose of is recommended, but not mandatory.
2. Children 18 months through 6 years of age are required to have 4 doses of DTP and/or DTaP to enter school, day care, or preschool programs. At ag a 5th dose of DTP or DTaP is recommended, but not mandatory. Children 7 years of age and older are required to have 3 doses of diphtheria and teta enter school.
3. Children less than 7 years old who have received doses of DT (Pediatric) instead of DTP or DTaP must have the medical contraindication section comp and signed.
4. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for Polio and DTP or DTaP but not for measles, mump rubella. Reconstructed dates for Polio and DTP or DTaP must be reviewed and approved by the local health department. Blood test results are NOT accep evidence of DTP immunity. Blood test verification of immunity is acceptable in lieu of Polio, measles, mumps, or rubella vaccination dates, but revaccina is more expedient. ("Check marks" for vaccines given are not acceptable.)
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except chickenpox.
6. All children over 12 months of age who attend school, day care, or preschool programs must have at least one (1) dose of measles vaccine given on or the first birthday. Beginning in September, 1992, children entering kindergarten and sixth grade must provide evidence of two (2) doses of measles vac The requirement for a second dose will progressively apply to additional grades in subsequent years. (1998-99: K-12)
7. Beginning in September, 1985, kindergarten pupils must have received rubella vaccine on or after the first birthday. This requirement will progressively a in one more grade each year until September, 1998, when it will apply in all grades. (1998-99: K-12)
8. Beginning in September, 1992, one dose of mumps vaccine given on or after the first birthday is required for pupils entering kindergarten and sixth grade. requirement will progressively apply to additional grades in subsequent years. (1998-99: K-12)
9. All children under 60 months of age must be vaccinated for *Haemophilus influenzae* type b. Children in kindergarten and above do not need to show evid of having *Haemophilus influenzae* vaccination.
10. Hepatitis B vaccine and chickenpox vaccine will be required for pre-k beginning September, 2000.
11. Effective September 1, 1995, Hepatitis B vaccine is required for licensed child care facilities for new enrollees born on/after April 1, 1994.
12. Chickenpox vaccine will be required for licensed child care facilities, effective September, 1998, for children born on/after January 1, 1997.

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

MEDICAL EMERGENCY PLAN

THE HEALTH CARE PROVIDER COMPLETES THIS FORM IF CHILD HAS A MEDICAL CONDITION THAT MAY REQUIRE EMERGENCY CAR AS REQUIRED BY COMAR 07.04.02.35.

Child's Name: _____ Date of Birth: _____

Medical Problem(s): _____

Allergies/Reactions: _____

_____

EMERGENCY INSTRUCTIONS:

A) Signs/symptoms to look for: _____

_____

B) When signs/symptoms appear do this: _____

_____

TO PREVENT INCIDENTS: _____

_____

DHR/CCA 1280 (7/92) Side 1

OTHER SPECIALIZED MEDICAL/HYGIENE PROCEDURES THAT MAY BE NEEDED:

_____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____ _____

Physician Signature. Physician Phone Number.

_____ _____

Physician Name (Print). Signature of Parent/Guardian.

DHR/CCA 1280 (7/92) Side 2

EMERGENCY INFORMATION

FOR CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

Child's Name _____ (Last) (First)

Birth Date _____ Enrollment Date _____

Hrs. & Days Of Expected Attendance _____

Child's Home Address _____ (Street/Apt. #) (City) (State) (Zip Code) (Telepc

Mother's Name _____ (Last) (First)

Mother's Employer or School _____

Business Address _____ (Street) (City) (State) (Zip Co

Business Telephone _____ Hrs. of Work _____ Days Off _____

Father's Name _____ (Last) (First)

Father's Employer or School _____

Business Address _____ (Street) (City) (State) (Zip Co

Business Telephone _____ Hrs. of Work _____ Days off _____

Name of Person Other than Parents Authorized to Pick up Child _____ (Last) (First) (Relationship t

Address _____ (Street/Apt. #) (City) (State) (Zip Code) (Telephc

DHR/CCA 1214 (Revised 3/95) Side 1

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emerg

1. Name _____ (Last) (First) Telephone _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Co

2. Name _____ (Last) (First) Telephone _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Co

3. Name _____ (Last) (First) Telephone _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Co

Child's Physician or Source of Health Care _____ Telephone _____

Address _____ (Street) (City) (State) (Zip Co

In **EMERGENCIES** requiring immediate medical attention, your child will be taken to the **NEAREST HOSPITAL EMERG ROOM.** Your signature authorizes the responsible person at the child care facility to have your child transported to that hospit

_____ _____

Signature of Parent/Guardian Date

UPDATES: *(Initials/Date)* _____

DHR/CCA 1214 (Revised 3/95) Side 2

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

Child's Name: _____ Birth Date: _____
Last First Middle

Name of Parent/Guardian: _____ Relationship: _____

Home Address: _____
Street City State Zip Code

Home Telephone: _____

ır Parent/Guardian:

Every child should have medical and dental health supervision periodically from birth to age 18. Even healthy children should see a doctor dentist at regular intervals. Health check-ups should include physical examinations and immunizations which are necessary to keep your child of communicable disease.

Maryland law requires you to submit proof of age-appropriate immunizations on the Maryland Immunization Certificate (DHMH 896) to the cer home, or school. This must be done before your child can be admitted.

This form requests health information from you (Part I) and from your child's Health Practitioner (Part II). The section you complete will be hel to the Health Practitioner in his evaluation of your child.

If is necessary that you also provide information for Form DHR/CCA 1214. This is the Emergency Information Form for Child Care Centers, Fan Child Care Homes, and Non-public Nursery Schools and Kindergartens.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: _____
Child Care Center, Family Child Care Home, School

Address: _____
Street

_____
City State Zip Code

PART I: CHILD'S INFORMATION

To be completed by PARENT/GUARDIAN

'PORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE T FORM WITH YOU TO THE HEALTH PRACTITIONER.

PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON T RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

		YES	NO
1.	Are you concerned about your child's general health *(eating, sleeping habits, posture, teeth, skin, menstruation, weight, bowel/bladder, etc.)*?	_____	_____
2.	Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)*?	_____	_____
	Date of last eye examination: ___/___/___ Doctor's Name: _____		
	Results: _____		
	Does your child wear glasses?	_____	_____
	Contact lenses?	_____	_____
3.	Does your child have any ear or hearing problems *(frequent earaches, difficulty hearing, etc.)*?	_____	_____
	Date of last hearing evaluation ___/___/___ Doctor's Name: _____		
	Results: _____		
	Does your child use a hearing aid?	_____	_____
4.	Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.)*?	_____	_____
	Does your child have any allergies? If *YES*, please state what kind of allergies:	_____	_____
	Does your child have any other specific illness, disability or other limiting condition? If *YES*, give details under "Remarks".	_____	_____
	(a) Does this condition require any special health care in the child care facility or school?	_____	_____
	(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or educational needs? If *YES*, give details under "Remarks"	_____	_____
	(c) Does your child require any adaptive equipment?	_____	_____
7.	Do you have concerns about your child's behavior or emotional well-being which the child care provider or school should know about? If *YES*, give details under "Remarks".	_____	_____

REMARKS *(Clarify any "YES" answers)*:

PARENT'S STATEMENT - ALL MUST SIGN AN DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT I FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEED IN DAY CARE OR SCHOOL.

Please fill in if child is school age:

I give my permission to _____ School to release _____'s
Name of School Name of Child

health information to _____
Name of Child Care Center, Family Child Care Home, Non-public Nursery School

TEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AN BELIEF.

_____ _____
Signature of Parent/Guardian Date

PART II: MEDICAL EVALUATION

To be completed by a HEALTH PRACTITIONER

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ___/___/___. Result: _____ Positive _____Negative.

2. This child has the following which may significantly affect his/her child care or educational experience:

			COMMENTS
a. Vision problem	☐ YES	☐ NO	_____
b. Hearing problem	☐ YES	☐ NO	_____
c. Speech or language problem	☐ YES	☐ NO	_____
d. Other physical illness or impairment	☐ YES	☐ NO	_____
e. Mental, emotional or behavior problems	☐ YES	☐ NO	_____
f. Developmental delays	☐ YES	☐ NO	_____
g. Allergies	☐ YES	☐ NO	_____

Significant physical findings, comments and recommendations: _____

3. This child has a health condition which may require care or emergency action while at child care/school. _____ YES _____NO

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

4. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

_____ YES _____NO If YES, please specify: _____

This child requires a modified diet and/or special feeding procedures. _____ YES _____NO

If YES, please specify: _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

6. If child cannot fully participate in all areas of day care program, what areas should be limited or altered to suit his/her needs?

_____

7. Does child's physical activity need to be restricted? _____ YES _____NO

If YES, specify: _____

8. Does this child require any specialized treatment? _____ YES _____NO

If YES, specify: _____

9. Does this child require any adaptive equipment (Braces, crutches, etc.)? _____ YES _____NO

If YES, please specify type: _____

Special instructions for use: _____

10. Additional comments: _____

_____

HEALTH PRACTITIONER'S STATEMENT

ucted a physical examination of the above-named child on _____ and find that he/she IS / IS NOT medically cleared to atter care or school.
(Date) (Circle one)

_____ (_____)_____

Name of Health Practitioner *(Please Print)* Telephone Number

_____ _____

Signature of Health Practitioner

PART III - ADDITIONAL COMMENTS

This page is to used by child care personnel to record signs of illness or accidents observed by the staff and to record when the p
as notified.

may be used to record reasons for absences and other information related to the child's health status.

Written recommendations by health practitioner or parents following absences may be attached to this record.

DATE	RECORDER	DETAILS