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

FROM: LINDA RISNER, 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

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<th>CHILD'S NAME</th>
<th>BIRTH DATE</th>
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has received appropriate screening and/or testing for lead poisoning.

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PLEASE RETURN THIS COMPLETED FORM TO:

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

Address: ____________________________
Street

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ATTENTION: ____________________________
**Maryland Immunization Certificate**

**Child's Name**

**Last**

**First**

**MI**

**Sex:** Male [ ] Female [ ]

**Birthdate**

**MO.** [ ] **Day.** [ ] **YZ.** [ ]

**County**

**School**

**Grade**

**Parent or Guardian Name**

**Address**

**City**

**Zip**

**Record of Immunization**

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**Physician, Health Official, School Official, or Day Care Provider**

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

Signed [ ]

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 [ ]

Parent or Guardian Date [ ]

**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 [ ]

**Religious Objection:**

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

Signed [ ]

Parent or Guardian Date [ ]
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 have a student in:
1. Preschool program unless the student has furnished evidence of age-appropriate immunity against Haemophilus influenzae type b;
2. Preschool program or kindergarten through the second grade of school unless the student has furnished proof of appropriate immunity against pertussis; and
3. Preschool program through the twelfth grade unless the student has furnished evidence of age-appropriate immunity against tetanus, diphtheria, poliomyelitis, measles, mumps, rubella, and varicella.

Immunization requirements for licensed child care centers (COMAR 07.04.02) and family day care homes (COMAR 07.04.) 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

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<th>Vaccine</th>
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<td>DTaP - Diphtheria and tetanus toxoids with acellular pertussis vaccine</td>
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<td>Polio - Polio vaccine, oral or injectable</td>
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<td>MMR - Measles, mumps, and rubella combined vaccine</td>
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<td>Hib - Haemophilus influenzae type b vaccine</td>
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<td>HBV - Hepatitis B vaccine</td>
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<td>Varicella - Chickenpox vaccine</td>
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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, if the 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 DTaP is recommended, but not mandatory.
2. Children 18 months through 6 years of age are required to have 4 doses of DTP or DTaP to enter school, day care, or preschool programs. At age 6-8, a 5th dose of DTP or DTaP is recommended, but not mandatory. Children 7 years of age and older are required to have 5 doses of diphtheria and tetanus vaccine.
3. Children born on or after January 1, 1997 who have received doses of DT (Pertussis) instead of DTP or DTaP must have the medical examination section on this form 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, mumps, rubella. Recommended dates for Polio and DTP or DTaP must be reviewed and approved by the local health department. Blood test results are NOT accepted evidence of DTb immunity. Blood test verification of immunity is acceptable in lieu of Polio, measles, mumps, or rubella vaccination dates, but records are more permanent. (Check marks for vaccinations 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 enter school, day care, or preschool programs must have at least one (1) dose of measles vaccine given on or before their first birthday. Beginning in September 1992, children entering kindergarten and sixth grade must provide evidence of two (2) doses of measles vaccine. The requirement for a second dose will be progressively applied to additional grades in subsequent years. (1995-99: K-12)
7. Beginning in September 1992, children entering kindergarten must have received rubella vaccine on or after the first birthday. This requirement will progressively be in place for grades one year until September 1998, when it will apply in all grades. (1996-99: K-12)
8. Beginning in September 1992, one dose of hepatitis B vaccine given on or after the first birthday is required for pupils entering kindergarten and sixth grade. Requirement will progressively be applied 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 evidence of receiving Haemophilus influenzae vaccination.
10. Hepatitis B vaccine and chickenpox vaccine will be required for those beginning September 2002.
11. Effective September 1, 1994, Hepatitis B vaccine is required for licensed child care facilities for new enrollees born on or after April 1, 1994.
12. Chickenpox vaccine will be required for licensed child care facilities, effective September 1992, for children born on or after January 1, 1997.

DHMH 394, Rev. 12/97 Center for Immunization
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 CARE AS REQUIRED BY CCMAR 07.04.22.35.

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 1230 (7/92) Side 1

OTHER SPECIALIZED MEDICAL/HYGIENE PROCEDURES THAT MAY BE NEEDED:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

COMMENTS: ___________________________

__________________________________________

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Physician Signature: ___________________________ Phone Number: ___________________________

Physician Name (Print): ___________________________ Signature of Parent/ Guardian: ___________________________

DHR/CCA 1230 (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 Address
Street Apt. # ___________________________ City ___________________________ State ____________ Zip Code ____________ Telephone ____________

Mother’s Name ____________________________________________ Last First
Mother’s Employer or School ____________________________________________

Business Address ____________________________________________________________
Street Address
Street Apt. # ___________________________ City ___________________________ State ____________ Zip Code ____________ Telephone ____________

Business Telephone ___________________________ Hrs. of Work ____________ Days Off ____________

Father’s Name ____________________________________________ Last First
Father’s Employer or School ____________________________________________

Business Address ____________________________________________________________
Street Address
Street Apt. # ___________________________ City ___________________________ State ____________ Zip Code ____________ Telephone ____________

Business Telephone ___________________________ Hrs. of Work ____________ Days Off ____________

Name of Person Other than Parents Authorized to Pick up Child ____________________________________________
Street Apt. # ___________________________ City ___________________________ State ____________ Zip Code ____________ Telephone ____________

Address ____________________________________________ Last First Relationship __________________

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 emergency:

1. Name ____________________________________________ Last First
   Telephone ____________________________________________
   Address ____________________________________________ Screen Apt. # Street Apt. City State Zip Code

2. Name ____________________________________________ Last First
   Telephone ____________________________________________
   Address ____________________________________________ Screen Apt. # Street Apt. City State Zip Code

3. Name ____________________________________________ Last First
   Telephone ____________________________________________
   Address ____________________________________________ Screen Apt. # Street Apt. City State Zip Code

Child’s Physician or Source of Health Care ____________________________________________ Telephone ____________
Address ____________________________________________ Screen Apt. # Street Apt. City State Zip Code

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

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

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

Childs Name: _____________________________ Birth Date: _____________________________

Last First Middle

Name of Parent/Guardian: _____________________________ Relationship: _____________________________

Home Address: Street City State Zip Code

Home Telephone: _____________________________

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 center 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 held 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, Family 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: _____________________________

City State Zip Code
PART I: CHILD'S INFORMATION

To be completed by PARENT/GUARDIAN

IMPORTANT: 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".

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 IS
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 ___________________________________________

Name of School

Name of Child

health information to

Name of Child Care Center, Family Child Care Home, Non-public Nursery School

I TEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND
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:
   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:

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HEALTH PRACTITIONER'S STATEMENT

I conducted a physical examination of the above-named child on and find that he/she IS / IS NOT medically cleared to attend 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 be used by child care personnel to record signs of illness or accidents observed by the staff and to record when the parent was notified.

It 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.

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