

# EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

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

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
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.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Mother's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Mother's Employer/School \_\_\_\_\_  
Name Address

Mother's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Father's Employer/School \_\_\_\_\_  
Name Address

Father's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Name of Person Authorized to Pick Up Child (daily) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

ANNUAL UPDATES \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

**INSTRUCTIONS TO PARENT:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_  
 LAST FIRST MI  
 SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_  
 PARENT OR GUARDIAN NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**RECORD OF IMMUNIZATIONS (See Notes On Other Side)**

Vaccines Type													
Dose #	DTP-DTaP DT-Td-Tdap Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Heb B Mo/Day/Yr	PCV7 Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV4 Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Other _____	Other _____	Other _____	Other _____
4													
5													

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

1. \_\_\_\_\_  
 Signature Title Date  
 (Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**Office Stamp**

**LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)**

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

**MEDICAL CONTRAINDICATION:**

The above child has a valid medical contraindication to being immunized at this time.

This is a  permanent condition  temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
 Physician or Health Officer

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.**

### **Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.14.02.44 and COMAR 13A.14.01.29 DHR COMAR and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____	_____	_____	_____	_____
_____	Last	First	Middle	Birth Date
Name of Parent or Guardian _____	_____	_____	_____	_____
_____	_____	_____	_____	Relationship
Home Address _____	_____	_____	_____	_____
City _____	State _____	Zip Code _____	_____	_____
Check Best Telephone Number to Reach You:				
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____	<input type="checkbox"/> Cell #: _____	_____	_____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

**Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.**

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City/Town State Zip Code

**PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION**

To be completed by **PARENT/GUARDIAN**

**CHILD'S NAME:** \_\_\_\_\_

**IMPORTANT:** COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	<b>YES</b>	<b>NO</b>
1. Are you concerned about your child's general health ( <i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i> )?	_____	_____
2. Does your child have any eye problems ( <i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i> )?  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 ( <i>frequent earaches, difficulty hearing, etc.</i> )?  Date of last hearing evaluation ____/____/____      Doctor's Name: _____  Results: _____  Does your child use a hearing aid? _____	_____  _____  _____	_____  _____  _____
4. Does your child have any speech problems ( <i>difficulty having speech understood, stammering, delayed speech development, etc.</i> )?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:  (a) Does this condition require any special health care in the child care facility?  (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?  (c) Does your child require any special adaptations or adaptive equipment?	_____  _____  _____  _____  _____	_____  _____  _____  _____  _____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

**REMARKS** (*Provide further explanation for all "YES" answers*): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 NEEDS IN CHILD CARE. **I ATTEST 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 INFORMATION**

To be completed by a **HEALTH PRACTITIONER**

**CHILD'S NAME:** \_\_\_\_\_

1. Date of this child's most recent tuberculin test: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_ Positive \_\_\_ Negative

**Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.**

2. Date of this child's lead screening: \_\_\_/\_\_\_/\_\_\_ Blood lead test dates: Test 1: \_\_\_/\_\_\_/\_\_\_ Test 2: \_\_\_/\_\_\_/\_\_\_

3. This child has the following which may significantly affect his/her child care 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: \_\_\_\_\_

4. This child has a health condition which may require care or emergency action while at child care.  YES  NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): \_\_\_\_\_

Recommendations: \_\_\_\_\_

5. 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: \_\_\_\_\_

6. This child requires a modified diet and/or special feeding procedures.  YES  NO

If YES, please specify: \_\_\_\_\_

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs? \_\_\_\_\_

8. Does this child's physical activity need to be restricted?  YES  NO

If YES, please specify: \_\_\_\_\_

9. Does this child require any specialized treatment?  YES  NO

If YES, please specify: \_\_\_\_\_

10. Does this child require any adaptive equipment (braces, crutches, etc.)?  YES  NO

If YES, please specify type: \_\_\_\_\_

Special instructions for use: \_\_\_\_\_

**RECORD OF IMMUNIZATIONS**

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

