Student Record Card 6

Maryland State Department of Education
Maryland Department of Health (MDH)
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
Rockville, Maryland

MARYLAND SCHOOLS RECORD OF PHYSICAL EXAMINATION

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 an authorized health care provider must be completed within nine months prior to entering the public school system or within six months after entering the system.** A physical examination form designated by the Maryland State Department of Education and the Maryland Department of Health must be used to meet this requirement.
- **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool 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 MDH 896).
- **Evidence of blood lead testing is required for all students who reside in a designated at risk area or who are enrolled in Medicaid when first entering Prekindergarten, Kindergarten, and Grade 1, and for all children born on or after January 1, 2015.** The Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (DHMH 4620) (or another written document signed by an authorized health care provider) shall be used to meet this requirement.

Exemptions from immunizations are permitted if they are contrary to a student's or family's religious beliefs, and require parent/guardian signature on MDH Form 896. Students also may be exempted from immunization requirements if an authorized health care provider certifies that there is a medical reason not to receive a vaccine. Exemptions from blood lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood Lead Testing Certificate must be signed by an authorized health care provider stating a questionnaire was done.

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 their educational experience, please complete Part I of this Physical Examination form. Part II must be completed by an authorized health care provider, or attach a copy of your child's physical examination to this form. If your child requires medication and or a treatment to be administered in school, you must have the authorized health care provider complete a medication and or treatment administration form for each medication and or treatment to be administered. These forms can be obtained from your child's school or online from the Montgomery County Public Schools (MCPS) website at *www.montgomeryschoolsmd.org*: MCPS Form 525-12, *Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement*, MCPS Form 525-13, *Authorization to Administer Prescribed Medication, Release and Indemnification Agreement,* MCPS Form 525-14, *Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector*. If you do not have access to an authorized health care provider or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.

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

PART 1 HEALTH ASSESSMENT **To be completed by parent/guardian**			MCPS ID#
Student's Name (Last, First, Middle)	Birthdate (Mo., Day, Yr.)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.
Parent/Guardian Names			
Where do you usually take your child for routine medical care? Name: Address:			Phone No.
When was the last time your child had a physical exam? Month Year			
When was the last time your child had a dental exam? Month Year			
Where do you usually take your child for dental care? Name: Address:			Phone No.

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any of the following? Please check yes or no below.

	Yes	No	Comments
Anaphylaxis or severe allergic reactions			
Allergies (Food, Insects, Medications, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavioral or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental Problems			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication? ☐ No ☐ Yes

If yes, name(s) of medications:_____

Will your child require any medication to be administered in school? ☐ No ☐ Yes

If yes, name(s) of medications:_____

Will your child require any emergency medications (epinephrine auto-injectors, inhalers, glucagon, Diastat, nebulized medication, etc.) to be administered in school? ☐ No ☐ Yes If yes, please list_____

Will your child require any special treatments (G-tube feedings, catheterizations, etc.) to be administered in school? ☐ No ☐ Yes

If yes, please list _____

Parent/Guardian Signature Date

PART II SCHOOL HEALTH ASSESSMENT **To be completed ONLY by authorized health care provider**	MCPS ID#

Student's Name (Last, First, Middle)	Birthdate (Mo., Day, Yr.)	Name of School	Grade

1. Does the child have a diagnosed medical condition? ☐ No ☐ Yes

   Specify _____

2. Does the child have a health condition which may require EMERGENCY ACTION while at school? (e.g., seizure, severe allergic reaction/anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please work with the school nurse to develop an emergency plan. ☐ No ☐ Yes

   Specify _____

3. Are there any abnormal findings on evaluation for concern? ☐ No ☐ Yes

   Specify _____

EVALUATION FINDINGS/CONCERNS

PHYSICAL EXAM	WNL	ABNL	Area of Concern	HEALTH AREA OF CONCERN	Yes	No
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings/health concerns.)

4. **RECORD OF IMMUNIZATIONS**: MDH 896 is required to be completed and attached by an authorized health care provider ***or*** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. ☐ No ☐ Yes

   _____

   (*MCPS Form 525-13, *Authorization to Administer Prescribed Medication, Release and Indemnification Agreement and/or MCPS Form 525-14, Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector, must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. ☐ No ☐ Yes

   _____

   _____

7. **Screenings**	**Results (actual value, or positive/negative)**	**Date Taken**
Tuberculin Test		
Blood Pressure/Heart Rate		
Height		
Weight		
BMI %tile		
Blood Lead Testing (DHMH 4620)		

PART II SCHOOL HEALTH ASSESSMENT *(continued)*
To be completed ONLY by authorized health care provider

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

☐ No evident problem that may affect learning or full school participation ☐ Problems noted above

Additional Comments:

Name of Authorized Health Care Provider (Type or Print)	Phone No.	Authorized Health Care Provider Signature	Date