## MONTGOMERY COUNTY PUBLIC SCHOOLS Rockville, Maryland 20850

## STUDENT RECORD CARD 6

Maryland State Department of Education Maryland State Department of Health

## 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 a physician or certified nurse practitioner 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 Department of Health and Mental Hygiene 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 DHMH 896).
- Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a student's or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official 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 certificate must be signed by a Health Care Practitioner 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 his/her educational experience, please complete Part I of this Physical Examination form. Part II 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 and or a treatment to be administered in school, you must have the physician complete a medication and or treatment administration form for each medication and or treatment to be administered. 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 Physical Examination form and return it to your child's school as quickly as possible.

PART 1 HEALTH ASSESSMENT	То	be compl	eted	by parent/gi	uardia	n	
Student's Name (Last, First, Middle)				Birthdate (Mo., Day, Yr.)	Sex (M/F)	Name of School	Grad
Address (Number, Street, City, State, Zip)						Phone No.	
Parent/Guardian Names							
Where do you usually take your child for rou	utine medi	cal care?	****			Phone No.	
Name:  When was the last time your child had a ph	ysical exan		1622:	Year			
Where do you usually take your child for de						Phone No.	
Name:		Add	ress:				
To the best of your k				STUDENT HE		the following? Please check	
	Yes	No		7.1		Comments	
Anaphylaxis							
Allergies (Food, Insects, Drugs, Latex)							
Allergies (Seasonal)							
Asthma or Breathing Problems							
Behavior or Emotional Problems							
Birth Defects							
Bleeding Problems							
Cerebral Palsy							
Dental							
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							
Serious Allergic Reactions							
Sickle Cell Disease							
Speech Problems							
Surgery							
Other							
Does your child take any medication?	□ No 「	   Vos					
Name(s) of Medications:							
Is your child on any special treatments:	? (nebuliz	er, epi-pen,	, etc.)	□ No □ Yes	5		
Treatment		· ·					
Does your child require any special pro	cedures?	(catheteriz	ation,	etc.) 🗌 No	☐ Yes		
Parent/Guardian Signature						Date	

(Mo, Day, Yr.)   (M/F)	PART II SCHOOL HEALTH ASSESSI To		pleted	ONLY by	Physician/N	urse Pra	actitioner		
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, severe allergic reaction/maphylants to lood or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE. Additionally, please "work with the school runse to develop an emergency plan?".   No   Yes    Specify	Student's Name (Last, First, Middle)						Name of School		Grade
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, severe allergic reaction/maphylants to lood or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE. Additionally, please "work with the school runse to develop an emergency plan?".   No   Yes    Specify	Does the child have a diagnosed medical	al conditio	n? □ N	o 🗆 Yes					
anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please PESCRIBE. Additionally, please "work with the school nurse to develop an emergency plan".   No   Yes    Specify	_								
Second	anaphylaxis to food or insect sting, asth please "work with the school nurse to d	ma, bleed evelop an	ing probl emergen	lem, diabete icy plan". [	s, heart problem ☐ No ☐ Yes	he/she is , or other	at school? (e.g., seizure, severe a problem) If yes, please DESCRIB	illergic read E. Addition	ction/ nally,
Second									
PHYSICAL EXAM	3. Are there any abnormal findings on eval	luation fo	concern	? □ No □	] Yes				
PHYSICAL EXAM WNL ABNL AREA OF CONCERN YES NO Head	Specify								
PHYSICAL EXAM WNL ABNL AREA OF CONCERN YES NO Head									
Head   Altention Deficit/Hyperactivity   Fees   No   Head   Altention Deficit/Hyperactivity   Fees   Pees   Hearing Development   Pees   Pees   Pees   Hearing Development   Pees   Pees   Pees   Pees   Hearing Disabilities/Problems   Pees   Pees   Pees   Pees   Pees   Hearing Disabilities/Problems   Pees   Pees   Pees   Pees   Pees   Pees   Head Exposure/Elevated Lead   Pees   P			EVALU	ATION FIN	IDINGS/CON	CERNS			
Eyes Behavior/Adjustment Development Devel	PHYSICAL EXAM	WNL	ABNL		Ι Η ΕΔΙΙΗ ΔΕ	REA OF C	CONCERN	Yes	No
Development Dental Bental Bespiratory Bespiratory Cardiac Bespiratory Cardiac Bead Exposure/Elevated Lead CI Bearing Disabilities/Problems CI Busculoskeletal/Orthopedic Nutrition Neurological Nutrition Neurological Physical Illness/Impairment Skin Psychosocial Psychosocial Speech/Language Vision Other REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a health care provider or a computer generated immunization record must be provided. 5. Is the child on medication? If yes, indicate medication and diagnosis. \  \to \  \to \  \text{Yes}  (A medication administration form 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. \  \to \  \text{Yes}  7. Screenings Tuberculin Test Blood Pressure Height Weight BMI %tile	Head				Attention [	Deficit/H	yperactivity		
Dental   Hearing   Respiratory   Immunodeficiency   Cardiac   Lead Exposure/Elevated Lead   Cardiac   Lead Exposure/Elevated Lead   Cardiac   Learning Disabilities/Problems   Cardiac   Cardiac   Mobility   Cardiac   Mobility   Cardiac   Cardi	Eyes				Behavior/A	djustme	nt		
Respiratory   Immunodeficiency   Cardiac   Lead Exposure/Elevated Lead   Cardiac   Learning Disabilities/Problems   Cardiac   Learning Disabilities/Problems   Cardiac   Learning Disabilities/Problems   Cardiac   Learning Disabilities/Problems   Cardiac   Mobility   Cardiac   Mobility   Cardiac   Mobility   Cardiac   Mobility   Cardiac   Cardiac   Mobility   Cardiac   Cardia	ENT				Developme	ent			
Cardiac GI GI Learning Disabilities/Problems GU Musculoskeletal/Orthopedic Nutrition Neurological Nutrition Neurological Physical Illness/Impairment Skin Psychosocial Psychosocial Findocrine Speech/Language Psychosocial Vision Other  REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a 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  (A medication administration form must be completed for medication in school). 6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. No Yes Tuberculin Test Blood Pressure Height Weight BMI 96tile	Dental				Hearing				
GI	Respiratory				Immunode	ficiency			
Musculoskeletal/Orthopedic Neurological Neurological Physical Illness/Impairment Skin Psychosocial Psychosocial Speech/Language Psychosocial Other  REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a health care provider or a computer generated immunization record must be provided. 5. Is the child on medication? If yes, indicate medication and diagnosis.	Cardiac				Lead Expos	sure/Elev	ated Lead		
Musculoskeletal/Orthopedic Neurological Nutrition Physical Illness/Impairment Skin Psychosocial Endocrine Speech/Language Psychosocial Other  REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a 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  (A medication administration form 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 Tuberculin Test Blood Pressure Height Weight BMI %tile	GI				Learning D	isabilitie	s/Problems		
Neurological Physical Illness/Impairment  Skin Psychosocial Psychosoci	GU				Mobility				
Skin	Musculoskeletal/Orthopedic				Nutrition				
Endocrine   Speech/Language   Vision   Other    REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a 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  (A medication administration form 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 Tuberculin Test Blood Pressure Height Weight BMI %tile	Neurological				Physical Illr	ness/Imp	pairment		
Psychosocial Vision Other  REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a 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  (A medication administration form 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 Tuberculin Test Blood Pressure Height Weight BMI %tile	Skin				Psychosoci	al			
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REMARKS: (Please explain any abnormal findings/health concerns.)  4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a health care provider or a computer generated immunization record must be provided.  5. Is the child on medication? If yes, indicate medication and diagnosis.  \( \text{No} \) Yes  (A medication administration form 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.  \( \text{No} \) Yes  7. Screenings Tuberculin Test Blood Pressure Height Weight BMI %tile	Psychosocial				Vision				
4. RECORD OF IMMUNIZATIONS: DHMH 896 is required to be completed and attached by a health care provider or a computer generated immunization record must be provided.  5. Is the child on medication? If yes, indicate medication and diagnosis.  \( \text{NO} \) \( \text{Yes} \)  (A medication administration form 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.  \( \text{NO} \) \( \text{Yes} \)  7. Screenings Tuberculin Test Blood Pressure Height Weight BMI %tile									
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6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.   7. Screenings Tuberculin Test Blood Pressure Height Weight BMI %tile	zation record must be provided.								
6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.   7. Screenings Tuberculin Test Blood Pressure Height Weight BMI %tile	(A medication administration form must	he compl	eted for n	nedication as	dministration in	school			
Tuberculin Test  Blood Pressure  Height  Weight  BMI %tile							of restriction.   No Yes		
Tuberculin Test  Blood Pressure  Height  Weight  BMI %tile									
Tuberculin Test  Blood Pressure  Height  Weight  BMI %tile									
Height Weight BMI %tile	7. <b>Screenings</b> Tuberculin Test	R	esults			Date Taken			
Weight BMI %tile	Blood Pressure								
Weight BMI %tile	Height								
BMI %tile									
	3								
	Lead Test		\t: '						

PART II SCHOOL HEALTH ASSESSMENT (continued) To be completed ONLY by Physician/Nurse Practitioner								
(Child's Name)			has had a complete physical exa	amination and has:				
$\square$ No evident problem that may affect learning or full school part	ticipation 🗆 P	roblems noted at	pove					
Additional Comments:								
Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse	Practitioner Signature	Date				
			J					