

## ALL ABOUT MY CHILD

### INSTRUCTIONS

This tool was developed to help your child care provider support the growth and development of your child while creating a safe stable and healthy environment for all children.

#### **STEP I: INFORMATION TO BE COMPLETED BY THE PARENT/GUARDIAN**

**IDENTIFYING INFORMATION:** Fill in identifying information including your child's nickname.

**THINGS MY CHILD DOES WELL:** Indicate characteristics of your child's behavior and skills which you consider to be things your child does well in the following areas: physical activity, language, self-care, emotional, and social. Examples could include your child's problem solving ability, inquisitiveness, expression of thoughts, sharing ability, climbing skills, ability to use a spoon, fork, or drinking cup. Your child care provider can use these examples to help your child develop new skills.

**WHAT MY CHILD LIKES AND DISLIKES:** Indicate your child's likes and dislikes including toys, objects, people, foods, and activities. Indicate if fear is associated with any dislikes and discuss with your provider. Making a note of your child's likes and dislikes will help the provider make your child feel more comfortable.

**THINGS I AM WORKING ON WITH MY CHILD:** Let the child care provider know the skills and activities that you consider important for your child to learn and ones that you are working on at home, through school, or with a private practitioner. These could include self-help skills, language skills, social skills, coordination, large muscle activities, and/or behavior skills. The provider may be able to reinforce these efforts and provide consistency when appropriate.

**MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES:** Describe those activities in which your child most enjoys participating, such as circle games, climbing, running, or bike riding. This knowledge will help the child care provider plan activities to include your child.

**MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES:** Indicate if your child dislikes, has difficulty with, or is physically restricted from performing certain activities. Examples of this may include a dislike of playing games with balls, falling frequently when climbing, or a restriction from participating in strenuous exercise.

**MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES:** Indicate if your child needs equipment to participate fully in the program. Equipment may include such things as glasses, a wheelchair, braces, crutches or other walking aids, a hearing aid, a helmet, a communication board, a nebulizer, special feeding utensils, and/or other adaptive devices. If applicable, include directions and demonstrate how the equipment is to be used. Indicate if the child requires any procedures or treatments. These may include blood glucose monitoring, catheterization, positioning, special exercises, a plan for emergency care, and/or a behavior management program. Directions may be provided by the parents, physician, or other professionals.

## ALL ABOUT MY CHILD

### INSTRUCTIONS (continued)

**THINGS MY CHILD MIGHT NEED HELP WITH:** Indicate if the child requires individual attention. This may be required only during certain activities or during the entire time the child is in care. Some examples are help with tying shoes, help with cutting food, or encouragement to participate in group activities or to sit still, reinforcement of a behavior management program, or intermittent catheterization. Any need for additional supervision is determined between the parent/guardian and the provider.

### STEP II: THE PROVIDER'S PART

**WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME?** (*For the use of the provider when necessary*): In addition to the established provisions of the program, indicate any modification of the program necessary to meet the unique needs of this child. Examples may include adding activities that this child especially likes or performs well, providing extra supervision when the child is performing difficult activities, removing anything to which the child is allergic, rescheduling activities so that they do not interfere with any treatments, moving furniture to accommodate wheelchairs, and adapting activities so that the child will be included. Decisions may be made in cooperation with the parent/guardian.

### STEP III: USE OF THE INFORMATION GATHERED

**ONGOING:** The provider should be familiar with the information gathered on this form before working with the child. *All information collected shall be confidential. Written parental permission must be obtained prior to sharing this information with anyone other than the provider(s) and the Child Care Administration's Licensing Specialist. The information needs to be updated as the child's need(s) change or at a minimum, annually.* Revision of program plans can occur at any time based on observations of the child or updated evaluations (it may be helpful to make updates in a different color ink). It is important that the parent/guardian and provider devote time to discuss the child's day-to-day behavior and participation in activities. By doing this routinely, problems can be prevented.

**DAILY:** The provider/staff must have daily access to each child's personal information in order to adequately provide for the safety and care of each child. The information may be used to schedule procedures, treatments, program modifications, and/or additional supervision. The provider plans the program of activities to enable each child to participate with the group as much as possible.

**ANNUALLY:** This information must be reviewed and updated *at least once a year* by the parent/guardian. The parent/guardian and provider must initial and date the form when it is reviewed each year.

**MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care**

**ALL ABOUT:** \_\_\_\_\_  
Child's First Name or Nickname

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Provider/Center: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

The information contained herein is for CONFIDENTIAL USE ONLY.

**THINGS MY CHILD DOES WELL**

**WHAT MY CHILD LIKES AND DISLIKES**

**THINGS I AM WORKING ON WITH MY CHILD**

**MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES**

**MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES**

**MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES**

**THINGS MY CHILD MIGHT NEED HELP WITH**

**WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME?**

(For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Updates:

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider: \_\_\_\_\_

## HEALTH INVENTORY

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

Child's Name: _____ Last First Middle	Birth Date: _____
Name of Parent/Guardian: _____	Relationship: _____
Home Address: _____ Street City State Zip Code	
Home Telephone: _____	

Dear Parent/Guardian:

Every child should have medical and dental health supervision from birth to age 18. Even healthy children should see a doctor and dentist at regular intervals. Health check-ups should include physical examination and immunizations which are necessary to keep your child free 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 helpful to the Health Practitioner in his evaluation of your child.

It is necessary that you provide information for this Form 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: \_\_\_\_\_  
Street

\_\_\_\_\_ 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 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". **YES NO**

1. Are you concerned about your child's general health (eating, sleeping habits, 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.)? \_\_\_\_\_

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, 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 education 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 teacher should know about? If YES, give details under "Remarks". \_\_\_\_\_

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

**PARENT'S STATEMENT – ALL MUST SIGN AND 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 NEEDS IN CHILD CARE OR SCHOOL.

*Please fill in, if child is school age:*

I give my permission to \_\_\_\_\_ School to release \_\_\_\_\_ Name of Child

Health information to \_\_\_\_\_ Name of Child Care Center, Family Child Care Home, Non-Public Nursery School

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

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: \_\_\_\_\_

5. 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 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?

\_\_\_\_\_

7. Does this child's physical activity need to be restricted? \_\_\_\_\_ YES \_\_\_\_\_ NO

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

8. Does this child require any specialized treatment? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please 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**

I conducted a physical examination of the above-named child on \_\_\_\_\_ and find that he/she **IS** / **IS NOT** medically cleared to attend child care or school. (circle correct response)

\_\_\_\_\_  
Name of Health Practitioner (Please Print)

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

\_\_\_\_\_  
Signature of Health Practitioner  
OCC 1215 (Revised 7/05) - All previous editions are obsolete

\_\_\_\_\_  
Date



**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 IMMUNIZATION (See Notes)**

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	PCV7 MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1							1				
2							2				
3							DOSE #	Varicella MO/DAY/YR	OTHER MO/DAY/YR	OTHER MO/DAY/YR	OTHER MO/DAY/YR
4							1				
5							2				

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

Office Stamp

1. \_\_\_\_\_  
 Signature Title Date  
(Medical provider, local health department official, school official, or day 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.



**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 Official

**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.

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 or stamping the signature section. A different medical provider, local health department official, school official, or day 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 day care service. **Only a medical provider, local health department official, school official, or day care provider may sign ‘Record of Immunization’ section of this form.**

### 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.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/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.

## CERTIFICATION INFORMATION

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 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 retain a student in a: 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 age-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 (rubeola), mumps, rubella, hepatitis B and 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). The requirement for hepatitis B and Varicella vaccine is a “progressive” regulation in which another successive grade becomes covered by the regulation with each new school year.

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the “**Maryland DHMH Recommended Childhood Immunization Schedule**”. Please refer to Department of Human Resources COMAR 07.04.02.44 and COMAR 07.04.01.29 for childcare center and family day care home regulations. DHR COMAR regulations and the “**Maryland DHMH Recommended Childhood Immunization Schedule**” are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).