Welcome!

Thank you for picking up this Kindergarten Enrollment Packet in preparation for the coming 2024-2025 school year. Along with the Enrollment Forms enclosed, the parent/legal guardian will need the following proofs in hand before contacting Parr's Ridge to schedule your enrollment completion and kindergarten assessment appointment:

1. identification of parent/legal guardian. (driver's license or court document indicating guardianship)

2. the **original** birth certificate/registration or passport to verify the child's birth date and name

3. to meet the requirements set forth by the State of Maryland, any ONE of the following proof of residence, in its entirety, is necessary: a **current** public utility bill such as BGE, Potomac Edison, or cable bill, which would need to list the parent/guardian's name and address as the "Service" address referenced in the upper portion of the bill; a land-line phone bill (**may not be a wireless phone bill**); a mortgage statement referencing name and address; a copy of a signed lease agreement which includes the tenant names/address as well as the signature pages of the tenant and landlord. Again, the proof of residence must be in its entirety. If the parent/legal guardian does not have any acceptable proof of residence listed here but lives with another individual who is named on the acceptable proofs listed, please be sure to complete the "CCPS Residence Verification Form" that is included. This Residence Verification form is ONLY NEEDED in such a case.

4. specific address from which the child will be transported to school, and the specific address to which the child will be transported after/from school. This information may be updated later, should circumstances change, with written notification from the parent/guardian.

You will need the Health Assessment and Immunizations Record, included in the enrollment packet, to be turned in on or before **August 1st, 2024**. This will complete the necessary paperwork needed for your child to start school on **September 3, 2024**. If you have any questions, please contact the office at 410-751-3559.

Parent/Guardian, when you have completed the attached Enrollment Forms and have all evidence listed, please email us at:

paraattendance@carrollk12.org
Subject Line: K-Enrollment

to let us know that you are prepared to complete the enrollment process where your child will be evaluated at that time.

Please email us to complete your child's enrollment as soon as possible.

Thank you!

Kindergarten Enrollment Check Off List

- **White enrollment form** filled out front and back.
  Do not sign the enrollment form on page 2 until we have you come in for the enrollment, so we can witness your signature.
- **Original proof of birth** –
  Acceptable documents
  a. Birth certificate
  b. Birth registration
  c. Passport
- **Proof of Residence** bill needs to be dated w/in 60 days and reference the service to address.
  Acceptable forms of proof are:
  a. Recent Bill for Services to the Home
  b. Signed Rental/Lease agreement
  c. Signed Settlement Document
  d. Property Tax Bill (current)
  e. Mortgage Statement /Bill
  f. Deed (owner's name and street address)
  g. Residence Verification Form along with current bill of owner
  h. Real Property Data Report
- **Home Language Survey**
- **Experience Prior to Enrollment** and specify the name of any Pre-K, Preschool or Day Care Center
- **Medical Documents** need to be received **on or before August 1st, 2024**.
- Do you have any **legal custody documents** currently in effect, including court orders regarding custody or visitation?

STUDENT ENROLLMENT FORM

Revised October 2022

CARROLL COUNTY PUBLIC SCHOOLS
125 N. Court Street, Westminster, MD 21157

INSTRUCTIONS: This form is to be completed by the parent or legal guardian. Maryland State regulations require verification of the following at the time of enrollment (unless homeless): proof of Carroll County residency, proof of birth and age requirements, and proof of immunizations. Enrollment is not complete, and the student cannot attend classes, until these documents are provided and verified. The biological or adoptive parent or legal guardian must personally appear and provide the required documents. The form must be signed in the presence of the school official accepting the documents.

CLEAR FORM

PLEASE COMPLETE BOTH PAGES OF THIS FORM. TYPE OR PRINT ALL INFORMATION.

SCHOOL _____ TODAY'S DATE _____

STUDENT INFORMATION

Legal First Name: _____ Middle Name: _____ Legal Last Name: _____ Gen: _____ (Jr., II, III, etc.)

☐ Male ☐ Female ☐ Non-binary Date of Birth: _____ Preferred Name: _____

Current Grade: _____

ETHNICITY: Are you Hispanic or Latino? Yes ☐ No ☐ (Please check regardless of the race(s) you select below.)

RACE(s): Please select one or more races below. The federal government provides only these categories and requires this information. If not completed, school personnel are required to make a selection.

American Indian/Alaskan Native(1) ☐ Asian(2) ☐ Black or African American (3) ☐ Native Hawaiian or Other Pacific Islander (4) ☐ White(5) ☐

Primary Language Spoken at Home: _____

PRIOR SCHOOL EXPERIENCE
Name of last school attended prior to this enrollment: _____ Grade: _____ Dates of Attendance: _____

_____ Address _____ City _____ State _____ Zip Code _____ Phone

Has the student ever attended a Carroll County Public School? Yes ☐ No ☐ If yes, name of last school: _____

STUDENT ADDRESS AND PHONE

Residence Address: _____ Apt # _____ House No. and Street Name _____ City _____ State _____ Zip Code

Transport TO school from this address? Yes ☐ No ☐ Transport FROM school to this address? Yes ☐ No ☐

Mailing Address: _____ (If different from residence address) Street Name/P.O. Box _____ City _____ State _____ Zip Code

Phone #: _____

Is your current address a temporary living arrangement? Yes ☐ No ☐ If yes, is this due to lack of housing or economic hardship? Yes ☐ No ☐ N/A ☐

PARENT/LEGAL GUARDIAN INFORMATION

(only parents/legal guardians living with the student should be listed here)

* Parent/legal guardian who does not live with the student will be listed on page 2. Stepparents must be listed as emergency contacts only.

Parent/Guardian #1 with whom student is residing: _____ *Legal First Name and Last Name* Relationship: Mother ☐ Father ☐ Legal Guardian ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Parent/Guardian #2 with whom student is residing: _____ *Legal First Name and Last Name* Relationship: Mother ☐ Father ☐ Legal Guardian ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Who has legal custody of this student? Mother ☐ Father ☐ Both ☐ Legal Guardian ☐ (Legal guardian must provide court documentation.)

Is there a current Custody or "No Contact Order"? Yes ☐ If yes, please provide the school with a copy of the current court order. No ☐ N/A ☐

Carroll County Public Schools (CCPS) does not discriminate on the basis of disability in employment or the provision of services, programs or activities. Persons needing auxiliary aids and services for communication should contact the Communications Office at 410-751-3020 or publicinfo@carrollk12.org, or write to Carroll County Public Schools, 125 North Court Street, Westminster, Maryland 21157. Persons who are deaf, hard of hearing, or have a speech disability, may use Relay or 7-1-1. Please contact the school system at least one (1) week in advance of the date the special accommodation is needed.

Information concerning the Americans with Disabilities Act is available from the Director of Facilities Management, (410) 751-3177, or the Communications Officer, (410) 751-3020, 125 North Court Street, Westminster, Maryland 21157.

*** RETAIN THIS FORM FOR 3 YEARS BEYOND THE YEAR TO WHICH IT APPLIES ***

PARENT/LEGAL GUARDIAN NOT LIVING WITH STUDENT

MOTHER: _____ FATHER: _____

Address: _____ Address: _____

Email Address: _____ Email Address: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

TRANSPORTATION INFORMATION

How will your child be transported to school? Bus ☐ Car Rider ☐ Day Care Transportation ☐ Drives ☐ Walker ☐

How will your child be transported home from school? Bus ☐ Car Rider ☐ Day Care Transportation ☐ Drives ☐ Walker ☐

Does the student have an IEP (Special Education Services)? Yes ☐ No ☐ Does the student have a 504 plan? Yes ☐ No ☐

Has the student participated in an ESOL program (for students that do not use English as their primary language)? Yes ☐ No ☐

Does the parent need an interpreter? Yes ☐ No ☐ Language Spoken at Home: _____

Is the student currently suspended from school? Yes ☐ No ☐ Has the student ever been expelled from school? Yes ☐ No ☐

If yes to either question, Name of School: _____ Phone: _____

Effective dates of suspension/expulsion: _____

The information as submitted on this form and on any attachments is accurate, complete and true to the best of my knowledge. I understand that enrollment will be complete upon receipt of all records and information. I also understand that any information that is misrepresented or falsified may result in tuition charges, or denial of enrollment. *Form must be signed in the presence of the school official completing enrollment.*

Parent/Legal Guardian Signature: _____ Date: _____

----- *FOR SCHOOL USE ONLY* -----

Proof of Birth: (Initial next to document received)

Birth Certificate _____ Birth Registration _____ Physician's Certificate _____ Hospital Certificate_____
Passport/Visa _____ Baptismal/Church Certificate _____ Parent's Affidavit (PPW approved) _____
Official School Record _____ Official Court Document _____

Residence Verification: (Initial next to document received) * Indicates document must be dated within 60 days of enrollment

Recent Bill for Services to the Home* _____ Turn on Notice _____ Signed Rental/Lease Agreement _____
Rent Receipt (current)* _____ Signed Settlement Document _____ Property Tax Bill (current) _____
Mortgage Statement/Bill* _____ Deed (with owner's name and street address) _____ Residence Verification Form with POR _____
Real Property Data Report _____ Student Services Approved (attach documentation) _____

Proof of Immunization Compliance: (Initial next to document received)

DHMH Certificate 896 _____ Clinic Record or Physician's Office Record _____ Other State Official Immunization Record _____
Official School Record _____

Start Date: _____ Entry Code:_____ A.M. Bus _____ P.M. Bus_____

Residency:

Foreign Exchange ☐ Kinship Care ☐ Non-Resident ☐ Out-of-County Living Arrangement ☐ Out-of-District ☐ SPED Placement ☐

Birth Country (for ALL students): _____ Date of 1st U.S. School Entry if Foreign-Born: _____

Other: _____

Signature/Title of School Official(s) Receiving Enrollment Documents: _____

Proof of Birth: _____ Proof of Residence: _____
Signature/Title/Date Signature/Title/Date

Immunizations: _____ _____
Signature/Title/Date Signature/Title/Completion Date of School Official Updating eSchoolPlus

School Use Only: _____ *Pre-Registration* _____ *Current Enrollment*

*** RETAIN THIS FORM FOR 3 YEARS BEYOND THE YEAR TO WHICH IT APPLIES ***

Carroll County Public Schools
Kindergarten Prior Care Form *(revised Jan 2019)*

Student Name: _____ Date of Birth: _____

The Maryland State Department of Education (MSDE) requires Carroll County Public Schools to collect information about the early care experiences of all newly enrolling Kindergarten students.

Predominant Prior Care - In what kind of early care did your child spend **most** of his/her time since September of the year prior to entering Kindergarten? Mark a maximum of one full-day or two half-days.

Prior Care	Full Day	Half-Day
Informal Care Care provided in a home by a relative or non-relative. Location: _____		
Head Start Program A federal pre-school program for 3 to 5 year olds from low income families: funded by the U.S. Department of Health and Human Services and licensed by the Maryland Department of Education, Office of Child Care. Location: _____		
PreKindergarten in a Public School Public school prekindergarten education for four year olds. Administration by local boards of education and regulated by the Maryland State Department of Education (MSDE) according to COMAR 13A.06.02 Prekindergarten Programs. (General Education or Special Education) Location: _____		
Child Care Center Child care provided in a facility, usually non-residential, for part or all of the day that provides care to children in the absence of a parent. The center is licensed by the Maryland State Department of Education. Office of Child Care. Location: _____		
Family Child Care Regulated care given to a child younger than 13 years old, in place of parental care for less than 24 hours, in a residence other than the child's residence and for which the provider is paid. Family child care is regulated by the Maryland State Department of Education, Office of Child Care. Location: _____		
Non-Public Nursery School Preschool programs with an "education" focus for 2, 3 or 4 year olds; approved or exempted by MSDE; usually part-day, nine months a year. Location: _____		
Kindergarten Student is repeating Kindergarten. Location: _____		

School Registrar:
Please enter this information into the "Kindergarten Prior Care" screen in ESP under Registration

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Carroll County Public Schools
Building the Future

Maryland Home Language Survey

In accordance with federal and state requirements, the Home Language Survey will be administered to all students and **used only for determining whether a student needs English language support services** and will not be used for immigration matters or reported to immigration authorities.

If a language other than English is indicated on two or more of the three questions below, the student will be assessed for English language support services. Additional criteria for testing may be considered.

Student Name:_____ **Birthdate:**_____

School:_____

1. What language(s) did the student first learn to speak?

2. What language does the student use most often to communicate?

3. What language(s) are spoken in your home?

For Staff: If a language other than English is identified in any of the questions above, send a copy to the Supervisor of ESOL Services.

Copy: Supervisor of ESOL – Central Office
File: Students Cumulative Record

Legal Name: Emergency Card School:

Address: Student ID: Homeroom:

Grade:

Primary Phone: Birthdate: Locker:

Transportation Information:

Before School (AM) Pick Up Bus #:	After School (PM) Pick Up Bus #:
☐ Bus Rider ☐ Car Rider ☐ Walker ☐ Daycare ☐ Drives	☐ Bus Rider ☐ Car Rider ☐ Walker ☐ Daycare ☐ Drives
Bus stop description where student is to be picked up in the AM.	Bus stop description where student is to be dropped off in the PM

Parent / Guardian Information: Only the biological parent(s)/legal guardian(s) may be listed here.

Guardian:	**Relation:**	**Guardian:**	**Relation:**
Address:		**Address:**	
E-Mail:		**E-Mail:**	
Primary Phone:	**Cell:**	**Primary Phone:**	**Cell:**
Work:	**Home:**	**Work:**	**Home:**

Student has a parent/guardian who is active duty military? ☐ Yes

Who has legal custody of this student? ☐ Father ☐ Mother ☐ Both ☐ Guardian **Court Order Provided?** ☐ Yes ☐ No

Who has physical custody of this student? ☐ Father ☐ Mother ☐ Both ☐ Guardian **Court Order Provided?** ☐ Yes ☐ No

Do you require language interpretation services to communicate with school staff? ☐ Yes **Language:** _____

Emergency Contacts *Identify people, other than those listed above, who are authorized to pick up your child in the event of an emergency.*

Name	Cell	Work	Home	Relation

Medical Information: Please answer the questions below regarding your child's medical needs.

In accordance with Carroll County Public Schools policy, students cannot carry medication to or from school. Medication must be delivered by the parent/guardian to a school official. A properly completed medication consent form (available online or at school) must accompany any medication administered at school. If your child requires immediate medical attention and 911 is activated, he/she will be taken to the nearest hospital by ambulance. Medical information will be released on a need to know basis, including to the hospital and/or emergency medical technician.

1. Please list your child's health concerns/medical conditions. The school nurse will contact you for further information:

2. Does your child have either of the following? If yes, please explain in the space below.

A.) Serious health problem or chronic condition? ☐ Yes ☐ No B.) Allergies (food, medication, other)? ☐ Yes ☐ No

3. Does your child take routine medication or supplements? If yes, list all prescription/non-prescription medications/supplements and the reason for taking them:

☐ Yes ☐ No

Healthcare Provider Name/Phone:

Dentist Name/Phone:

Authorization: Please review and verify all information on this form, then sign and date below.

Your signature gives CCPS permission to release your child to any person listed above in the event of illness or emergency. Signature of step-parent or non-custodial parent is not acceptable. Providing an email address is optional. However, an email address is necessary for a parent/guardian to establish and maintain a Home Access Center account. The email address provided will be utilized by CCPS staff to communicate with you about your student and to communicate school and system wide information. CCPS utilizes an automated notification system that will contact you at the phone number you provided above.

X _____ _____

Parent/Legal Guardian Signature Date

Carroll County Public Schools
125 N. Court Street | Westminster, MD 21157
410-751-3000
410-751-3034 TTY
410-751-3003 FAX
Building the Future
Cynthia McCabe, Ed.D.
Superintendent

CCPS RESIDENCE VERIFICATION STATEMENT

Student: _____ *Date of Birth:* _____

School: _____

We hereby certify that the above referenced student and his/her parent(s)/guardian(s) reside on a full-time basis with a Carroll County resident. That resident is:

_____

The address of that residence is:

_____

Attach one of the following as proof of legal residence in Carroll County:

- a signed lease/rental agreement on a home/apartment in which the parent/legal guardian is currently residing
- a current rent receipt*
- a recent bill for a service delivered to the residence,* including a turn on notice or welcome letter (e.g.; BGE, land-line phone, cable, oil, water)*
- a mortgage statement / bill *
- a signed settlement document
- a deed (must show parent/legal guardian's name, house number and street name – plat information is not acceptable)
- a property tax bill from the current fiscal year indicating "primary residence"
- signed Residence Verification Statement accompanied by an acceptable proof of residence for the owner/lessee of the property
- a signed contract on a home being built in Carroll County for families with approved non-resident or out-of-district status (an acceptable proof of residence must be provided as soon as the family moves into the county or the district).
- other (with prior Pupil Personnel Worker approval – *Only*)

***Date on document must be within 60 days of enrollment**

We (the student, parent(s)/guardian(s) and the person with whom we live) have been informed of the residency requirements of Carroll County Public Schools and are aware copies of Board of Education Policy JECB (Admission of Non Resident Out-of-County Pupils) and the administrative regulations that support this policy are available upon request.

Finally, we are aware that providing false information regarding residency can result in a payment of back tuition owed to Carroll County Public Schools, immediate withdrawal from Carroll County Public Schools, and a referral to the Office of the State's Attorney for investigation and possible prosecution for felony theft.

I/we solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this paper are true.

_____ _____ _____ _____

Parent/Legal Guardian Signature *Date* *Parent/Legal Guardian Signature* *Date*

_____ _____

Signature of Person Owning, Renting, or Leasing the Site of Residency *Date*

Revised 6/23

PARR'S RIDGE SCHOOL HOURS

REGULAR FULL DAY:

STUDENTS MAY ENTER THE BUILDING AT 8:45 A.M.

SCHOOL DAY BEGINS AT 9:15 A.M.

DISMISSAL TAKES PLACE AT 3:45 P.M.

SCHEDULED 2 HRS 45 MINUTE EARLY DISMISSALS:

(AS REFERENCED IN THE INFORMATION CALENDAR PROVIDED TO STUDENTS AT THE START OF EACH SCHOOL YEAR)

STUDENTS WILL DISMISS AT 1:00 P.M.

Email Address: parattendance@carrollk12.org

Kindergarten Supply List for Parr's Ridge Elementary
2024 - 2025 School Year

1 scissors
8 - standard pencils
8 - pack of wide markers
1 - box crayons
1 - book bag – large enough to hold a standard sized pocket folder
1 - hinged plastic pencil box
1 - pocket folder (any color)
4 - glue sticks
1 – marble composition book, wide-ruled
1 – package thin dry erase markers
1 - highlighter

We would love donations of extra glue sticks, crayons – both standard, family sized tissue boxes, Purell, plastic baggies – gallon, quart, and sandwich sizes, colored pencils, ½ inch 3 ring poly binder, and packs of 3 oz playdough.

Please put your **child's name ONLY on their folders, composition book, backpack, and lunch box or change purse. All other items DO NOT need to be labeled.**

Carroll County Health Department

Susan Doyle, R.N.
Health Officer

Robert P. Wack, M.D.
Deputy Health Officer

290 South Center Street
Westminster, Maryland 21157
Main: 410-876-2152
FAX: 410-876-4988
Toll-Free: 800-966-3877
Website: cchd.maryland.gov

Public Health
Prevent. Promote. Protect.

Re: School Entry Requirements

Dear Parents:

The Carroll County School Health Program is a joint endeavor of the Carroll County Board of Education and the Carroll County Health Department. It is our goal to work with all parents and guardians in the county to keep our children safe and healthy in an environment which enables them to achieve their full potential. We want to remind you of several **requirements for school entry**:

1. A **physical examination is required,** and a **dental visit strongly recommended** before your child enters kindergarten and/or any Maryland public school for the first time. 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. After your health care provider and dentist complete the accompanying examination and immunization records, please return them to your child's school.
2. **Completed certificate of blood lead testing is required for all students when first entering Pre-Kindergarten, Kindergarten, or 1st grade.** Please read the instructions and complete the blood lead certificate found in your child's packet. It must be signed by your child's health care provider.
3. **Evidence of age-appropriate immunization.** Diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, chicken pox, hepatitis B, and meningitis infections are vaccine preventable diseases. Your child must be immunized against these diseases by your family health care provider, the Health Department, or another vaccine provider. As required by Maryland state law, a parent or guardian must provide prior to school entry documentation to the preschool or school authority on the Maryland Immunization Certificate (Form MDH 896). You may obtain a copy of your child's record by going to https://md.myir.net/ "My Immunization Record (MyIR)". MyIR is a portal that allows you to access your or your child's official vaccination records online. If you do not have either of these forms, you may present a computer-generated form from your health care provider or other official government immunization records for the school nurse to review (i.e.: a State immunization/baby book, CDC/WHO immunization booklets, etc.) These must have the child's name and date of birth and must be signed/stamped by the provider who gave the vaccination. If you have questions about these requirements, please contact your health care provider or the Carroll County Health Department at (410) 876-4949.

In addition, as part of our comprehensive School Health Program, the Carroll County Health Department will perform **vision and hearing screening** for children in pre-kindergarten, kindergarten, 1st, 4th, and 8th grades during the school year. After the screening, you will be notified of the results of the screening via a secure e-mail and/or letter.

Very truly yours,

Dr. Robert P. Wack, M.D.
Deputy Health Officer

Revised 01/11/2023

Student Enrollment Health Questionnaire

Student Name:_____ **Date of Birth:**_____ **Entering Grade:**_____

Entering School:_____ **Previous School attended:** _____

Health Care Provider Name: _____

Health Care Provider Phone Number:_____

MEDICAL CONCERNS (Please circle yes or no)			**Medications/Additional Comments**
ADHD	Yes	No	
Allergies to food, insects, latex, other	Yes	No	(If yes, please indicate specific allergy)
Asthma or other breathing related problems	Yes	No	
Bleeding Disorder	Yes	No	
Diabetes	Yes	No	
Gastrointestinal Issues	Yes	No	
Headaches/Diagnosed Migraines	Yes	No	
Cardiac/Heart Related Concerns	Yes	No	
Seizure Disorder	Yes	No	
Orthopedic concerns/assistive Devices	Yes	No	
Mental Health Issues	Yes	No	
Any other Health Concerns? Eating/sleeping, skin/teeth, weight, daytime wetting/stooling concerns	Yes	No	

My child takes the following medication at home: _____

My child will take the following medications daily at school: _____

My child will have the following medication as needed at school including emergency medication such as Epi-pen, Glucagon, Benadryl, inhaler, nebulizer medication or seizure medication:

_____

*If YES, a CCPS Medication Order Form must be completed for <u>each prescription and over-the-counter medication to be given at school</u>. CCPS Medication Order Forms must be completed by your health care provider **each** school year. Adults must deliver and pick up all medications. PARENT INITIALS:_____ Today's date_____*

Please provide a name and phone number where the nurse can contact you for further questions. Thank you!

Name: _____ *Phone Number:* _____

1/4/2024

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 shall be used to meet this requirement. https://2019-dsd.maryland.gov/regulations/Pages/13A.05.05.07.aspx
- **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 health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at: https://health.maryland.gov/phpa/OIDEOR/IMMUN/Shared%20Documents/MDH_896_form.pdf.
- **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 Maryland Department of Health Blood Lead Testing Certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: https://health.maryland.gov/phpa/OEHFP/Documents/MDH%20Blood%20Lead%20Testing%20Certificate%202023.fillable.pdf

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' 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.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf. **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 school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

Part 1 Health Assessment

To be completed by parent or guardian

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____ Phone _____

Address (Number, Street, City, State, Zip) _____

Parent / Guardian Names _____

Where do you usually take your child for routine medical care? Phone _____

Name _____ Address _____

When was the last time your child had a physical exam? Month _____ Year _____

Where do you usually take your child for dental care? Phone _____

Name _____ Address _____

Assessment of Student Health

To the best of your knowledge, has your child has any problem with the following? Please check and provide comments if yes.

Student Health Issues	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalizations (When, Where)			
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			

Part 1 Health Assessment - continued

To be completed by parent or guardian

Does your child take any medication?

No Yes Name(s) of Medications _____

No Yes Treatment _____, etc.

Does your child require any special procedure(s) (catheterization, etc.)?

No Yes Specify _____

_____ _____

Parent / Guardian Signature Date

Part II – School Health Assessment

*To be completed **ONLY** by Physician / Nurse Practitioner*

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____

1. Does the child have a diagnosed medical condition?

   No Yes _____

   _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".

   No Yes _____

   _____

3. Are there any abnormal findings on evaluation for concern?

   No Yes _____

   _____

Evaluation Findings / Concerns

Physical Exam	WNL	ABNL	Area of Concern
Head			
Eyes			
ENT			
Dental			
Respiratory			
Cardiac			
GI			
GU			
Muscoskeletal / Orthopedic			
Neurological			
Skin			
Endocrine			
Psychosocial			
Other			

Health Area of Concern	Yes	No
Attention Deficit / Hyperactivity		
Behavior / Adjustment		
Development		
Hearing		
Immunodeficiency		
Lead Exposure / Elevated Lead		
Learning Disabilities / Problems		
Mobility		
Nutrition		
Physical Illness / Impairment		
Psychosocial		
Speech / Language		
Vision		
Other		

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer-generated immunization record must be provided.

Part II – School Health Assessment - continued

*To be completed **ONLY** by Physician / Nurse Practitioner*

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).
   http://test.msde.maryland.gov/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

   No Yes _____

   _____

7. Screenings

Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

(Child's 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:

_____

_____

_____

_____

_____

_____

_____ _____

Physician / Nurse Practitioner (Type or Print) Phone

_____ _____

Physician / Nurse Practitioner (Signature) Date

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

Maryland

STUDENT/SELF NAME: _____ (LAST) _____ (FIRST) _____ (MI)

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: ____/____/____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1														
2														
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr		
4														
5														

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

Clinic / Office Name
Office Address/ Phone Number

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.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____ (Date)

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ (Medical Provider / LHD Official) Date _____

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 vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

Maryland

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by 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 MDH 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; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

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 MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____ (LAST) _____ (FIRST) _____ (MI)

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____ (MM/DD/YYYY)

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ (Name) _____ (Title)

_____ (Signature) _____ (Date)

2. _____ (Name) _____ (Title)

_____ (Signature) _____ (Date)

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____ (Provider Initial)

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ (Parent/Guardian Signature) _____ (Date)

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

Carroll County Public Schools
School Dental Record

Name of Student_____ DOB_____

Name of School _____ Grade_____

Dental caries are the most common disease of childhood. Regular dental examinations, good oral hygiene habits, healthy diets, and modern advances in dental disease prevention and control, can benefit everyone. If your child has not visited your family dentist within the last six months, we advise you to make an appointment immediately. After the dental appointment, the signed form should be returned to the school.

Report of Dental Examination:

A._____ No dental treatment is necessary at this time.

B._____ All necessary dental treatment has been completed.

C._____ Treatment in progress.

D._____ A regular preventative care program is recommended.

Further recommendations: _____

_____

_____

_____

_____

_____

_____

Dentist Name (Print):_____ Date:_____

Dentist Signature:_____ Date:_____

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