

**¡Bienvenido!**

**Gracias por recoger este paquete de inscripción de kindergarten en preparación para el próximo año escolar 2024 - 2025. Si necesita un intérprete, háganoslo saber en la hoja de información de contacto y haremos que un intérprete se comunice con usted.**

1. Identificación del padre/madre/tutor legal. (licencia de conducir o documento judicial que indique la tutela)
2. el acta de nacimiento/registro o pasaporte original para verificar la fecha de nacimiento y el nombre del niño
3. para cumplir con los requisitos establecidos por el Estado de Maryland, se necesita cualquiera de los siguientes comprobantes de residencia, en su totalidad: **una factura actual de** servicios públicos como BGE, Potomac Edison o factura de cable, que deberá incluir el nombre y la dirección del padre/tutor como la dirección de "Servicio" a la que se hace referencia en la parte superior de la factura; **una factura de teléfono fijo (no puede ser una factura de teléfono móvil)**; un estado de cuenta de la hipoteca que haga referencia al nombre y la dirección; Una copia de un contrato de arrendamiento firmado que incluya los nombres/direcciones del inquilino, así como las páginas de firmas del inquilino y del propietario. Una vez más, la prueba de residencia debe ser en su totalidad. Si el padre/tutor legal no tiene ningún comprobante de residencia aceptable en esta lista, pero vive con otra persona que está nombrada en los comprobantes aceptables enumerados, asegúrese de completar el "Formulario de verificación de residencia de CCPS" que se incluye. Este formulario de verificación de residencia SOLO es NECESARIO en tal caso.
4. dirección específica desde la cual el niño será transportado a la escuela, y la dirección específica a la que el niño será transportado después / desde la escuela. Esta información puede actualizarse más adelante, en caso de que cambien las circunstancias, con una notificación por escrito del padre/tutor.

Necesitará que el Registro de Evaluación de Salud e Inmunizaciones, incluido en el paquete de inscripción, se entregue el **1 de agosto de 2024** o antes. Esto completará la documentación necesaria para que su hijo comience la escuela el **3 de septiembre de 2024**. Si tiene alguna pregunta, comuníquese con la oficina al 410-751-3559.

**Padre/Tutor, cuando haya completado los Formularios de Inscripción adjuntos y tenga todas las pruebas enumeradas, envíenos un correo electrónico a:**

**[parattendance@carrollk12.org](mailto:parattendance@carrollk12.org)**

**Línea de asunto: K-Enrollment**

**para hacernos saber que está preparado para completar el proceso de inscripción en el que su hijo será evaluado en ese momento.**

**Envíenos un correo electrónico para completar la inscripción de su hijo lo antes posible.**

**¡Gracias!**

# Lista de Inscripción en Kindergarten

- Si necesita un intérprete, la escuela se comunicará con nuestro departamento de interpretación para programar una cita de inscripción.
- **Comprobante de nacimiento original** –  
**Documentos aceptables**
  - a. Certificado de nacimiento
  - b. Registro de nacimiento
  - c. Pasaporte
- **La factura de comprobante de residencia** debe estar fechada en 60 días y hacer referencia al servicio a la dirección.  
**Las formas aceptables de prueba son:**
  - a. Factura reciente por servicios al hogar
  - b. Contrato de alquiler/arrendamiento firmado
  - c. Documento de liquidación firmado
  - d. Proyecto de Ley de Impuestos a la Propiedad (actual)
  - e. Estado de cuenta de la hipoteca / Factura
  - f. Escritura (nombre del propietario y dirección)
  - g. Formulario de verificación de residencia junto con la factura actual del propietario
  - h. Informe de datos de bienes inmuebles
- **Encuesta sobre el idioma del hogar**
- **Experiencia previa a** la inscripción y especificar el nombre de cualquier centro de prekínder, preescolar o guardería
- **Los documentos médicos** deben recibirse **antes del 1 de agosto de 2024.**
- ¿Tiene algún **documento de custodia legal** actualmente vigente, incluidas las órdenes judiciales con respecto a la custodia o las visitas?

# 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: \_\_\_\_\_ Relationship: Mother ☐ Father ☐ Legal Guardian ☐  
Legal First Name and Last Name

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

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

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](mailto: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 1<sup>st</sup> U.S. School Entry if Foreign-Born: \_\_\_\_\_

Other: \_\_\_\_\_

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

Proof of Birth: \_\_\_\_\_    Signature/Title/Date \_\_\_\_\_    Proof of Residence: \_\_\_\_\_    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
<b>Informal Care</b> Care provided in a home by a relative or non-relative. Location: _____		
<b>Head Start Program</b> 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: _____		
<b>PreKindergarten in a Public School</b> 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: _____		
<b>Child Care Center</b> 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: _____		
<b>Family Child Care</b> 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: _____		
<b>Non-Public Nursery School</b> 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: _____		
<b>Kindergarten</b> Student is repeating Kindergarten. Location: _____		

**\*School Registrar:**

**Please enter this information into the "Kindergarten Prior Care" screen in ESP under Registration**



## 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







# 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/leasee 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



## **Lista de útiles de jardín de infantes para Parr's Ridge Elementary Año escolar 2024 – 2025**

1 – Tijeras  
8 - Lápices estándar  
8 – Paquetes de marcadores anchos  
1 - caja de lápices de colores  
1 - Bolsa de libros  
1- Lo suficientemente grande como para contener un  
folder de boisillo tamaño estándar  
1 – estuche plástico con bisagras para lápices

1 – Folder con boisillos (cualquier color)  
4 - Barras de pegamento  
1 – Libro de composición de mármol, de rayas anchas  
1 – paquete de marcadores finos de borrado en seco  
1 – plumón resaltador/iluminador (fluorescente)

Nos encantaría recibir donaciones de barras de pegamento adicionales, crayones, cajas de pañuelos estándar de tamaño familiar, Purell, bolsas de plástico, tamaños de galón, cuarto de galón y sándwich, lápices de colores, carpeta de polietileno de 3 anillos de 1/2 pulgada y paquetes de plastilina de 3 oz.

**Por favor, ponga el nombre de su hijo SOLO en sus folders, libro de composición, mochila y lonchera o bolso de cambio. Todos los demás artículos NO necesitan estar etiquetados.**

### **HORAS DE ESCUELA PARR'S RIDGE**

DÍA COMPLETO REGULAR:

LOS ESTUDIANTES PUEDEN INGRESAR AL EDIFICIO A LAS 8:45 A.M.

EL DÍA ESCOLAR COMIENZA A LAS 9:15 A.M.

LA SALIDA SE REALIZA A LAS 3:45 P.M.

SALIDAS ANTICIPADAS PROGRAMADAS DE 2 HORAS Y 45 MINUTOS:

(COMO SE MENCIONA EN EL CALENDARIO DE INFORMACIÓN QUE SE PROPORCIONA A LOS ESTUDIANTES AL COMIENZO DE CADA AÑO ESCOLAR)

LOS ESTUDIANTES SALDRÁN A LA 1:00 P.M.

Email Address [parattendance@carrollk12.org](mailto:parattendance@carrollk12.org)

# Carroll County Health Department

Susan Doyle, R.N.  
Health Officer

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



**Public Health**  
Prevent. Promote. Protect.

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

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, 1<sup>st</sup>, 4<sup>th</sup>, and 8<sup>th</sup> 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

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A Founding Member of *The Partnership for a Healthier Carroll County, Inc.*



## 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 each prescription and over-the-counter medication to be given at school. 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: \_\_\_\_\_

## 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](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	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				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



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: \_\_\_\_\_ Date: \_\_\_\_\_  
Medical Provider / LHD 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 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



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](http://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](http://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

# 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  $\geq 3.5$  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: \_\_\_\_\_