

Carroll County Health Department

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Public Health
Prevent. Promote. Protect.

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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 have completed the accompanying examination and immunization records, please return them to the school where your child is enrolled.
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. Your certificate requires completion and signature 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 serious diseases which can be prevented. Your child must be immunized against these diseases by your family health care provider, the Health Department, or another vaccine provider. Maryland State law requires that prior to school entry, a parent or guardian must provide documentation to the preschool or school authority on the Maryland Immunization Certificate (Form MDH 896) or you may obtain a copy of your child's record by going to <https://md.myir.com>. "My Immunization Record (MyIRMobile)". MyIRMobile 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

**Medical Forms must be
completed by your doctor and
handed in at the enrollment
appointment**

Revised 01/11/2023, 1/9/2025

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

Maryland Schools Record of Physical Examination

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			

Maryland Schools Record of Physical Examination

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.

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-DTSP-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	Vanzella Mo/Day/Yr	Vanzella 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: _____

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



**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: _____