Carroll County Health Department
Public Health
Matthew Levy, MD, MPH, FAAP
Deputy Health Officer
Cynthia A. McCabe, Ed.D.
Superintendent of Schools
Building the Future
Carroll County Public Schools

Re: School Entry Requirements

Dear Parents/Guardians:

The Carroll County Board of Education and the Carroll County Health Department want to make sure that your child and all children in Carroll County Public Schools (CCPS) are safe, healthy, and can achieve their full potential. This starts by working together to make sure all children complete their health requirements.

The health requirements for your child to start school in CCPS are:

1. **Your child must have a physical exam by a doctor or certified nurse practitioner (CNP) no more than nine months before they start at CCPS or no more than six months after they start.**
    - Your child's provider needs to fill out exam and immunization forms.
    - Please return these forms to your child's school.

2. **A dental visit is strongly recommended before your child enters kindergarten and/or any Maryland public school for the first time.**

3. **Your child must have a blood test for lead. High levels of lead can affect brain health.**
    - Your child's provider will complete a form about blood lead testing.
    - This is required for all students when first entering Pre-Kindergarten, Kindergarten, or 1st grade.
    - You also need to sign this form.

4. Your child must have proof of required vaccinations.
    - Required vaccines are tested, safe and effective at preventing serious diseases.
    - Maryland state law requires that you provide documentation to the preschool or school.
    - The Maryland Immunization Certificate (Form MDH 896) link is on the Health Department's website at https://health.maryland.gov/carroll/Pages/Vaccines-for-Children.aspx.
    - You can also get a copy of your child's record by going to https://myirmobile.com/.
    - If you do not have either of these forms, you can present a form from your health care provider or other official 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.

In addition, as part of our School Health Program, the Carroll County Health Department provides vision and hearing screening for children in pre-kindergarten, kindergarten, 1st, 4th, and 8th grades during the school year. After the screenings, you will receive the results via a secure email and/or letter. We will also share information on what to do if your child needs follow-up testing.

Thank you for doing your part to make sure your child is ready for a healthy school year! If you need any of the following services for your child, please visit the Health Department's website at health.maryland.gov/carroll or call 410-876-2152.

- **Children's Immunization Clinic** - Vaccines for children birth through age 18 who have no insurance, are underinsured, have Medical Assistance, or are American Indian or Alaskan Native
- **Children's Dental Clinic** - Dental services for children from 6 months up to 18 years who have no insurance or enrolled in the Maryland Medical Assistance Program for dental services, called Maryland Healthy Smiles.
- **Maryland Children's Health Insurance Program (MCHP)** - Medical Assistance for Children
- **Women, Infants, and Children (WIC)** - Healthy food and nutrition support for women and children up to age 5 who qualify
- **Car seat safety** - Car seat loans and free car seat checks

**SIGNATURES**

Dr. Matthew Levy
Deputy Health Officer Medical Director
Carroll County Health Department

Kerrie Wagaman, RN, MSN, NCSN
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Carroll County Public Schools

# 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:* _____

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 | 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 | | |
| Muscoskeletal / 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

Maryland
DEPARTMENT OF HEALTH

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.

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.

Clinic / Office Name
Office Address/ Phone Number

**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. (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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