MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
ALL ABOUT: _____
Child's First Name or Nickname

Child's Name: Birthdate:

Parent/Guardian: Home Phone: Work Phone:

Address: Zip Code:

Provider/Center: Phone:

Address: Zip Code:

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES
MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES
THINGS MY CHILD MIGHT NEED HELP WITH
WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the Child Care Facility when needed.)

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

Signatures:

Parent/Guardian: _____ Date: _____

Provider: _____ Date: _____

Updates:

Parent/Guardian: _____ Date: _____ Parent/Guardian: _____ Date: _____

Provider: _____ Provider: _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

ALL ABOUT MY CHILD

INSTRUCTIONS

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

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

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

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

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

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

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

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

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

ALL ABOUT MY CHILD

INSTRUCTIONS (continued)

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

STEP II: THE PROVIDER'S PART

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

STEP III: USE OF THE INFORMATION GATHERED

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

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

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

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address (*If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address *(If different from above)* _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

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

Child's Name: _____ Birth Date: _____
Last First Middle

Name of Parent/Guardian: _____ Relationship: _____

Home Address: _____
Street City State Zip Code

Home Telephone: _____

Dear Parent/Guardian:

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

Maryland law requires you to submit proof of age-appropriate immunizations on the Maryland Immunization Certificate (DHMH 896) to the center, home, or school. This must be done before your child can be admitted.

This form requests health information from you (Part I) and from your child's Health Practitioner (Part II). The section you complete will be helpful to the Health Practitioner in his evaluation of your child.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: _____
Child Care Center, Family Child Care Home, School

Address: _____
Street

_____
City State Zip Code

PART I: CHILD'S INFORMATION

To be completed by **PARENT/GUARDIAN**

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER.

PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

		YES	**NO**
1.	Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	_____	_____
2.	Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	_____	_____
	Date of last eye examination: _____/ _____/ _____ Doctor's Name: _____	_____	_____
	Results: _____		
	Does your child wear glasses?	_____	_____
	Contact lenses?	_____	_____
3.	Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	_____	_____
	Date of last hearing evaluation _____/ _____/ _____ Doctor's Name: _____		
	Results: _____		
	Does your child use a hearing aid?	_____	_____
4.	Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.*)?	_____	_____
5.	Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6.	Does your child have any other specific illness, disability or other limiting condition? If YES, give details under "Remarks".	_____	_____
	(a) Does this condition require any special health care in the child care facility or school?	_____	_____
	(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or education needs? If YES, give details under "Remarks".	_____	_____
	(c) Does your child require any adaptive equipment?	_____	_____
7.	Do you have concerns about your child's behavior or emotional well-being which the child care provider or school teacher should know about? If YES, give details under "Remarks".	_____	_____

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

PARENT'S STATEMENT – ALL MUST SIGN AND DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS IN CHILD CARE OR SCHOOL.

Please fill in, if child is school age:

I give my permission to _____ School to release _____
Name of Child

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

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Signature of Parent/Guardian Date

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: _____/ _____/ _____ Result: _____Positive _____Negative

2. This child has the following which may significantly affect his/her child care or educational experience:

			COMMENTS
a. Vision problem	☐ YES	☐ NO	_____
b. Hearing problem	☐ YES	☐ NO	_____
c. Speech or language problem	☐ YES	☐ NO	_____
d. Other physical illness or impairment	☐ YES	☐ NO	_____
e. Mental, emotional or behavior problems	☐ YES	☐ NO	_____
f. Developmental delays	☐ YES	☐ NO	_____
g. Allergies	☐ YES	☐ NO	_____

Significant physical findings, comments and recommendations: _____

3. This child has a health condition which may require care or emergency action while at child care/school. _____ YES _____ NO

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

4. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

_____YES _____ NO If YES, please specify: _____

5. This child requires a modified diet and/or special feeding procedures. _____ YES _____ NO

If YES, please specify: _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

6. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

_____

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

If YES, please specify: _____

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

If YES, please specify: _____

9. Does this child require any adaptive equipment (braces, crutches, etc.)? _____ YES _____ NO

If YES, please specify type: _____

Special instructions for use: _____

10. Additional comments: _____

HEALTH PRACTITIONER'S STATEMENT

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

_____ (_____)_____

Name of Health Practitioner (*Please Print)* Telephone Number

_____ _____

Signature of Health Practitioner Date

PART III – ADDITIONAL COMMENTS

This page is to be used by child care personnel to record signs of illness or accidents observed by the staff and to record when the parent was notified.

It may be used to record reasons for absences and other information related to the child's health status.

Written recommendations by health practitioner or parent following absences may be attached to this record.

DATE	RECORDER	DETAILS

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY - ADDENDUM

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

Under Maryland law, a child under six years of age who is admitted to child care must have appropriate screening for lead poisoning. Parent(s) or guardian(s) must submit evidence of this screening to the child care provider within 30 days of admission to care. Under Maryland law, children who reside (or have ever resided) in certain areas of the State designated as at-risk for childhood lead poisoning must receive one or more blood lead tests. The at-risk areas requiring blood lead testing (per list revised May 2004 by DHMH), and instructions for that testing, are specified on the back of this form.

To be completed by a HEALTH PRACTITIONER:

_____ _____
Child's Name **Child's Birth Date**

has received appropriate lead screening and/or blood lead testing.

NOTE - If this child resides, or has ever resided, in an area listed on the back of this form, provide the following information about the child's blood lead testing: Test #1 _____ Test #2 _____
Date Date

_____ _____
Signature of Health Practitioner **Date**

_____ _____
Address **Telephone**

_____
City/Town **State** **Zip Code**

To be completed by the child's PARENT/GUARDIAN:

_____ _____
Name of Child's Parent or Guardian Telephone

_____
Address

_____
City/Town State Zip Code

* *

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: _____
(Child Care Center, Family Child Care Home, School)

Address: _____
Street

_____
City/Town State Zip Code

TO THE ATTENTION OF: _____

At Risk Areas by Zip Code and Blood Lead Testing Instructions

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required. The child's health care provider should record the test dates on this form and certify them by signing or stamping the signature section of the form. All forms should be kept on file with the child's health records.

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227

Baltimore (cont.)
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748

P.G. (cont.)
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

* Maryland State Department of Education, Office of Child Care Health Inventory Lead Addendum (OCC 1215-A)
* Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (DHMH 4620, rev. May 2004)
  Both available in PDF format http://www.fha.state.md.us/och/html/lead.html

For more information on blood lead testing, contact your Local Health Department

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

MEDICATION ORDER FORM

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions. Prior written permission from the child's parent is a requirement. If possible, arrange the time of dosage so the child receives the medication at home. Fill out a separate form for each prescription or non-prescription drug.

PRESCRIPTION MEDICATIONS: Prescription medications must be in a container labeled by the pharmacy or physician with the child's name and expiration date. The child may receive medication only according to the written instructions of the health practitioner or the medication label, as show below.

NON-PRESCRIPTION MEDICATIONS: A child may receive only one dose per illness, except acetaminophen (Tylenol) and topical medication. A licensed health practitioner must approve the medication and dosage for the child to receive more than one dose.

Name of Child: _____

This medication is being given for the following condition(s): _____

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
ADDITIONAL INSTRUCTIONS (including instructions not given on the prescription):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				

I/We authorize _____ to administer the above named medication to my/our child.
Name of Child Care Provider or Facility

Signature of Parent: _____ Date: _____

COMPLETE ONLY IF MORE THAN ONE DOSE OF NON-PRESCRIPTION MEDICATION IS TO BE GIVEN	
Instructions for more than one dose of a non-prescription medication:	
Note any side effects of this medication:	
Note any reasons or conditons when this medication should be stopped or not given:	
Signature of Health Practitioner:	Date:
Stamp, Print or Type Name of Health Practitioner	Phone Number
If the above section is not signed by the health practitioner, the health practitioner/designee must give oral permission to the provider directly, and the provider must complete the following:	
Name of Practitioner or designee giving approval:	
Signature of person receiving approval from health practitioner:	Date: Time:

MEDICATION ADMINISTERED

The Provider or facility shall maintain a record of the administration of medication.
Keep this form in the child’s permanent record while the child remains in the care of this provider or facility.

Child’s Name:	Date to stop giving medication:
Medication:	

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATION (See Notes)

VACCINE TYPE							VACCINE TYPE				
DOSE #	DTP-DTaP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	PCV7 MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1							1				
2							2				
3							DOSE #	Varicella MO/DAY/YR	History of Varicella Disease Date - MO/YR	OTHER_____ MO/DAY/YR	OTHER_____ MO/DAY/YR
4							1				
5							2				

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

Office Stamp

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or 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.

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

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

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Physician or Health Officer

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child.

Signed: _____ Date: _____

HOW TO USE THIS CERTIFICATE OF IMMUNIZATION

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per 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.

CERTIFICATION INFORMATION

The following excerpt from the DHMH 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; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization). The requirement for hepatitis B and Varicella vaccine is a "progressive" regulation in which another successive grade(s) become covered by the regulation with each new school year.

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 07.04.01.29A, 07.04.02.44A and COMAR 07.04.05.34A. DHR COMAR and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guidelines chart are available at www.EDCP.org (Immunization).