Leslie A. Redwine
Head of School

ST. ANDREW'S UNITED METHODIST DAY SCHOOL

Kristin Leach
Assistant Head of School

Dear Parents and Guardians,

In preparation for the 2010 -2011 academic school year, enclosed are the necessary medical forms to be completed. These forms must be on file and in the health room prior at the start of the school year for compliance with Anne Arundel County regulations.

Students entering **preschool through kindergarten** are required to have a new Health Assessment form completed by their physician and on file **every year**.
Students in **grades 1-8** are required to have a new Health Assessment form completed by their physician and on file **every 2 years**.

If your child needs medication during the school day, your physician must fill out the Parents Request to Administer Medication form. This pertains to prescription and over-the-counter medications, including vitamins and cough drops. **No medication of any type will be given at school without this form**.

Please complete and return all health forms to the school front office before the first day of school.

Mrs. Dianne Myers
Health Aide

4 Wallace Manor Road, Edgewater, MD 21037 (410) 266-0952
www.standrewsum.org

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

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 No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

	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			
Hospitalization (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			

Does your child take any medication?

No Yes Name(s) of Medications: ____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No Yes Treatment ____

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

No Yes

Parent/Guardian Signature ____ Date:____________________

PART II - SCHOOL HEALTH ASSESSMENT

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

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

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?

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		

REMARKS: (Please explain any abnormal findings.)

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.

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).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ____

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

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) ____ has had a complete physical examination and has:

9 no evident problem that may affect learning or full school participation   9 problems noted above

____

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date

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).

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

CHILD'S NAME ________________________ / ________________ / ________________
LAST FIRST MIDDLE

CHILD'S ADDRESS ________________________ / ____________ / ________ / ________
ADDRESS CITY STATE ZIP

SEX: ☐ MALE ☐ FEMALE BIRTHDATE ______ / ______ / ______

COUNTY ________________ SCHOOL ________________________ GRADE ______

PARENT ________________ / ________________ / ____________ / ____________
OR LAST FIRST MIDDLE PHONE
GUARDIAN ________________________ / ____________ / ________ / ________
ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003**,** the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

RECORD OF BLOOD LEAD TESTING

Test #1. ________ **Test # 2.** ________ Comments: ________________________
Date Date

Signature ________________________________ / ________
Health Care Provider or Designee OR School Health Professional or Designee Date

RECORD OF BLOOD LEAD TESTING EXEMPTION

I, ________________ certify that my child does not **AND** has never resided in an at-risk area.
Parent or Guardian (Print)

Signature ________________________ / ________
Parent or Guardian Date

COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

RELIGIOUS OBJECTION:

1. 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. Signed ________________________ / ________
   Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed ________________________ / ________
   Health Care Provider Date

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) and certify them by signing or stamping the signature section. 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. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237

Baltimore Co. (Cont.)
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

Frederick . (Cont)
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

Montgomery (Cont)
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
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 Department of Health and Mental Hygiene Blood Lead Testing Certificate http://www.fha.state.md.us/och/html/lead.html

ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

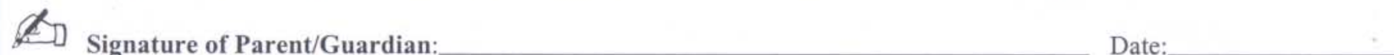
Name of Student:____ D.O.B:____/____/____
(LAST) (FIRST) (MI)

Name of School:______________________________ Grade:________ School Year:______________

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
  Name of child. *Name of the medication.* *Dosage, route and time of administration.*
  Name of physician. *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for Epi-Pen) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.



Signature of Parent/Guardian:______________________________ Date:______________

Relationship to student______________________________

Phone Number: (H)________________ (W)________________ Other________________

Address: ____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM

Diagnosis: ____

Name of Medication: ____

Dosage: ______________________________(mg, ml, ml/tsp, # of puffs)

Route:______________ Time of Administration at School: ______________________ ☐ Lunchtime

If PRN, for what symptoms? ______________________How Often? ______________

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

____

Services should begin (Date) ______________ and terminate (Date) ______________

FOR INHALER, EPI-PEN, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or Epi-pen.

Physician's Signature: ______________________________ Date:______________

Original signature/NO stamps

Physician's Name (Printed): ______________________________

Address: ____

Telephone Number: ____

☐ Order Reviewed ______________________________R.N. Date______________