QUEST
Quality Education
for Every Student

STUDENT RECORD CARD
SR-6
(Local)
Revised 9/00

HEALTH INVENTORY

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 either nine months prior to entering the public school system or within six months after entering the system. The physical examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene (SR-6, [Local], Revised 5/30/91) or a comparable health inventory form must be used to document that this requirement has been met.
- Evidence of complete primary immunizations against common childhood communicable diseases is required for all students in nursery through the twelfth grade. A Maryland Immunization Certificate (Form DHMH 896) for newly enrolling students may be obtained from the local health department or from school personnel. This form and the required immunizations must be completed before a child may attend school.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a student's religious beliefs. Students may also be exempted from immunization requirements if a physician or certified nurse practitioner certifies that it would create a medical problem for the student.

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.

In order to assist your child in gaining the most from his/her educational experience, please complete Part I of this Health Inventory form. Part II must be completed by a physician or certified nurse practitioner or attach a copy of your child's physical examination to this form.

If your child requires medication to be administered in school, you must have the physician or certified nurse practitioner complete the medication administration form. This form can be obtained from your child's school. If you do not have access to a physician or certified nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or nurse/health aide in your child's school.

You are asked to complete Part I of this Health Inventory form. Part II is to be completed by the physician or the certified nurse practitioner who examines your child.

Maryland State Department of Education
Maryland State Department of Health and Mental Hygiene
Prince George's County Public Schools

PART I -- STUDENT HEALTH HISTORY

-- To be completed by parent/guardian --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

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

Parent or Legal Guardian Names

Where do you usually take your child for 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, does your child have a history of or any problems with the following. Please check yes or no.

	Yes	No	Comments
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problem or Deafness			
Speech Problem			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Allergies, (Food, Insects, Drugs, etc.)			
Behavior or Emotional Problem			
	Yes	**No**	**Comments**
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			

Does your child take any medication(s)? ❑ Yes ❑ No

Name of Medication(s) _____

Parent or Legal Guardian Signature _____ Date _____

PART II -- STUDENT HEALTH ASSESSMENT / PHYSICAL EXAMINATION

-- To be completed by physician or certified nurse practitioner --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

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

1. Does this child have a health condition which may require EMERGENCY ACTION while he/she is at school: (e.g., seizure, insect sting, asthma, allergy, bleeding problem, diabetes, heart problem?) If yes, please DESCRIBE.

❑ No ❑ Yes _____

_____

2. Is the student on long-term medication? If yes, please DESCRIBE.

❑ No ❑ Yes _____

_____

(A Medication administration form must be completed for in-school administration.)

3. Is this child on long-term technology assistance?

❑ No ❑ Yes _____

(Please note specifics) _____

_____

4. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a 3 in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			
Scoliosis				Other			

REMARKS: (Please explain any "yes"; include recommendation for referral and treatment.)

_____

_____

_____

5. Should there be any restriction of physical activity in school? If so, specify nature and duration of restriction.

❑ No ❑ Yes _____

_____

6. Tuberculin Test: Results Type Date of last test	Blood Pressure Height Weight Date Taken
❑ Positive ❑ Negative	

If you would like to discuss this student's health with school or school health personnel, check title below

❑ Nurse assigned to school ❑ Teacher(s) ❑ Counselor ❑ Principal ❑ School Health Physician ❑ Other

(Student Name) _____ has had a complete physical examination and has

❑ no evident problem that may affect learning **OR** ❑ problems noted above.

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

-- Additional Comments on Reverse Side --

Additional Comments: