MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH HISTORY FORM

For Use in Drop-In Child Care Centers*

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____ Relationship: _____

Check the correct answers to the following questions. Give a brief explanation under COMMENTS for any YES answer.

Does the child have any of the following?	YES	NO	COMMENTS
a) Vision problem?			
b) Hearing problem?			
c) Speech or language problem?			
d) Physical illness or impairment problem?			
e) Mental, emotional or behavioral problem?			
f) Developmental delay?			
g) Allergies?			
h) Other? *(If YES, specify)*			
i) Health condition which may require care or emergency action*? (If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.) Attach plan for addressing incidents should they arise.*			
j) Does the child have up-to-date immunizations?			
k) Is the child currently taking any medication?			

This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities.

YES	NO

List any areas of the program in which the child cannot fully participate. Would any limits or alterations help to meet his or her needs? Please explain briefly.

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

* A parent may object when medical examination of a child conflicts with the parent's bona fide religious belief and practice. Under such circumstances, the parent may also use this form.