New Student Information

Office of Shared Accountability, Records Unit
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20850

MCPS Form 560-24
February 2019

INSTRUCTIONS: This form is to be completed by parent/guardian or eligible student. For all students new to or reentering MCPS, the verification of the following must be presented at the time of enrollment: Montgomery County residency, age and immunizations, unless homeless.

STUDENT INFORMATION

Must match birth certificate or other evidence of birth

Legal Last Name ______________________ Legal First Name__________ Legal Middle Name__________

Student's Preferred First Name ____

Social Security Number *(not required)* __ __ __-__ __-__ __ __ __ Date of Birth _____/_____/______ ❏ Male ❏ Female

School Name____ MCPS ID# _________ Grade _____

MARYLAND HOME LANGUAGE SURVEY

In accordance with federal and state requirements, the Home Language Survey will be administered to all students and **used only for determining whether a student needs English language support services** and will not be used for immigration matters or reported to immigration authorities.

If a language other than English is indicated on two of the three questions below, the student will be assessed for English language support services. Additional criteria for testing may be considered.

What language(s) did the **student** first learn to speak? ____________________________________

What language does the **student** use most often to communicate? ______________________________

What language(s) are spoken in your home? ____

PROOF OF AGE—(evidence of birth) Indicate which document was provided

❏ Birth Certificate ❏ Passport/Visa ❏ Physician's Certificate ❏ Baptismal or Church Certification ❏ Hospital Certificate ❏ Parent's Notarized Affidavit

❏ Birth Registration ❏ Other Legal or Notarized Identification (Specify) ______________________________

RESIDENCY

Street Address ____ City____________________

State ______ Zip___________ E-mail Address ____

Primary Home or Cell Phone Number _____ - _____ - ______

Circumstances (if applicable)

❏ Homeless Child/Unaccompanied Youth (complete MCPS Form 335-77, *Homeless Status*)

❏ Informal Kinship Care (complete MCPS Form 334-17, *Affidavit: Children in Informal Kinship Care*)

❏ Maryland State Supervised Care (complete MCPS Form 560-35, *Enrollment of Child in Maryland State-Supervised Care and Transfer of Educational Records*)

Proof of Residency—MCPS Regulation JEA-RB, Enrollment of Students, requires a copy of one of the following unless homeless:

❏ Current property tax bill ❏ Current lease ❏ If original term of the lease is expired, a copy of lease and current utility bill

❏ Shared Housing Disclosure Form (MCPS Form 335-74)

LANGUAGE FOR WRITTEN COMMUNICATION

❏ Amharic ❏ Chinese ❏ English ❏ French ❏ Korean ❏ Spanish ❏ Vietnamese

IMMIGRANT SERVICES AND EXEMPTIONS FROM CERTAIN TESTS

For the purpose of determining eligibility for immigrant services and/or exemption from certain tests, please provide the following information:

Was the student born outside of the United States? ❏ Yes ❏ No ***If Yes***: How many months has the student been in U.S. K–12 schools?____

Date student entered a U.S. K–12 **school** for the first time_____/_____/______

IMMUNIZATIONS

Proof of immunization compliance—MCPS Regulation JEA-RB, *Enrollment of Students*, requires a copy of one of the following:

❏ Maryland Department of Health Immunization Certificate 896

❏ Computer-generated printout from doctor's office ❏ Other ______________________________

ETHNICITY

1. **ETHNICITY DESIGNATION.** Read the definition below and check the box that indicates this student's heritage.
   Is this student Hispanic or Latino? (Select one answer.) ❏ Yes ❏ No
   Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered **Hispanic or Latino.**
2. **RACE DESIGNATION.** Check the boxes that indicate this student's race. **You must select at least one race, regardless of ethnicity designation. More than one response can be selected. Indicate this student's race.** (Select all that apply.)
   ❏ American Indian or Alaskan Native ❏ Asian ❏ Black or African American ❏ Native Hawaiian or Other Pacific Islander ❏ White

PRIOR SCHOOL EXPERIENCE

Has student previously attended a Montgomery County Public School? ❏ Yes ❏ No

If Yes: Last Montgomery County Public School attended______________________________

Dates of attendance _____/_____/______ to _____/_____/______ Last Grade_____

NAME AND ADDRESS OF LAST SCHOOL ATTENDED

____

Date of withdrawal _____/_____/______ Last Grade_____ ❏ Public School ❏ Private School

ADULT(S) RESPONSIBLE FOR STUDENT*

Name of adult responsible for student living at current address: ______________________	**Name of adult responsible for student living at current address:** ______________________
Relationship: ❏ Mother ❏ Father ❏ Guardian ❏ Other ______________________	**Relationship:** ❏ Mother ❏ Father ❏ Guardian ❏ Other ______________________
Employer ______________________	Employer ______________________
Phone #1 _____-_____-______ Phone #2 _____-_____-______	Phone #1 _____-_____-______ Phone #2 _____-_____-______
Phone #3 _____-_____-______	Phone #3 _____-_____-______
Name of parent/guardian *(if other than responsible adult above:)* ______________________	**Name of parent/guardian** *(if other than responsible adult above:)* ______________________
Relationship: ❏ Mother ❏ Father ❏ Guardian ❏ Other ______________________	**Relationship:** ❏ Mother ❏ Father ❏ Guardian ❏ Other ______________________
Address______________________	Address______________________
Phone _____-_____-______	Phone _____-_____-______

***** ❏ Responsible Adult(s) Legal Identification (including photograph) and proof of relationship to student verified (specify)

Is the student a dependent of a member of the Active Duty Forces (full-time) Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or Reserve Forces (Army, Army National Guard of the U.S., Navy, Air Force, Marine Corps, Air National Guard of the U.S., or Coast Guard)? ❏ Yes ❏ No

Sibling's (name)	Birthdate	Current School
______________________	_____/_____/______	______________________
______________________	_____/_____/______	______________________
______________________	_____/_____/______	______________________

NON-CUSTODIAL PARENT (if applicable)

Name ____

Address____

Custody concerns? ❏ Yes ❏ No If yes, contact school.

OTHER INFORMATION

Does the student have an Individualized Education Program (IEP)?	❏ Yes	❏ No
Does the student have a Section 504 plan?	❏ Yes	❏ No
Has the student been an English learner receiving ESOL/ESL/ENL* services in a Language Instruction Educational Program (LIEP) in a U.S. school? ***If Yes***, date first entered ESOL/ESL/ENL/LIEP in a U.S. school _____/_____/______ If exited, what was the exit date? _____/_____/______ **ESOL—English for Speakers of Other Languages/ESL—English as a Second Language/ENL—English as a New Language*	❏ Yes	❏ No
Has the student ever been suspended from school? ***If Yes***, is the student currently suspended?	❏ Yes ❏ Yes	❏ No ❏ No
Has the student ever been expelled from school? ***If Yes***, is the student currently expelled from school?	❏ Yes ❏ Yes	❏ No ❏ No
If enrolling after start of school year, do you want directory information to be withheld? ***If Yes***, complete MCPS Form 281-13, *Annual Notice for Directory Information and Student Privacy*.	❏ Yes	❏ No

The information as submitted on this form and on any attachments is accurate, complete and true to the best of my knowledge. I understand that falsification of any information submitted shall be cause for denial of enrollment. Furthermore, I understand I am responsible for reporting to the school principal if the student becomes a non-resident of this county and that I am liable for tuition for any periods that the student may be a non-resident, unless homeless. If student has an IEP, I understand that an IEP team must determine student's placement.

______________________________________ _____/_____/______

Signature, Parent/Legal Guardian or Eligible Student *Date*

Maryland State Department of Education
Prekindergarten Experience

Department of Elementary Curriculum and Districtwide Programs
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20850

MCPS Form 345-17
February 2019

INSTRUCTIONS: The Maryland State Department of Education (MSDE) requires Montgomery County Public Schools (MCPS) to collect information about the early care experiences of all newly enrolling kindergarten students. Using the definitions provided below, please provide the following information and return to the school in which your child will be enrolled along with MCPS Form 560-24, *New Student Information*.

Student Name (Last, First, Middle) ________________________________ Date of Birth_____/_____/______

School ____

In what kind of care did the child spend most of their time since September of the previous year?

Place one check in the correct box for full day or two checks in the correct half day boxes.

Include the name of the school, center, or provider on the line.

PRIOR CARE	NAME OF PRIOR CARE SCHOOL, CENTER, OR PROVIDER	FULL DAY	HALF DAY—1	HALF DAY—2
Informal Care		❏	❏	❏
Head Start		❏	❏	❏
Prekindergarten in a public school (general education or special education)		❏	❏	❏
Child Care Center		❏	❏	❏
Family Child Care		❏	❏	❏
Nonpublic Nursery School		❏	❏	❏
Kindergarten (repeated)		❏	❏	❏

MSDE Defined Categories of Early Care Experiences

Informal Care	Care provided in a home by a relative or non-relative.
Head Start Program	A federal pre-school program for 3- to 5-year olds from low income families: funded by the U.S. Department of Health and Human Services and licensed by the Maryland Department of Education, Office of Child Care.
Prekindergarten in a public school	Public school general or special education prekindergarten for four year olds administered by MCPS and regulated by MSDE according to COMAR 13A.06.02 Prekindergarten Programs school (general education or special education in a public school)
Child Care Center	Child care provided in a facility, usually non-residential, for part or all of the day that provides care to children in the absence of a parent. The centers are licensed by the Maryland State Department of Education, Office of Child Care.
Family Child Care	Regulated care given to a child younger than 13 years old, in place of parental care for less than 24 hours, in a residence other than the child's residence and for which the provider is paid. Family child care is regulated by the Maryland State Department of Education, Office of Child Care.
Non-public Nursery Schools	Pre-school programs with an "education" focus for 2,3, or 4 year olds; approved or exempted by MSDE; usually part-day, nine months a year.

Student Emergency Information

Office of Student and Family Support and Engagement
Montgomery County Public Schools
Rockville, Maryland 20850

MCPS Form 565-1
February 2019

INSTRUCTIONS: Please complete both sides of this form and return to your child's school as soon as possible.

Student Name (Last, First, Middle)			Student's Preferred First Name
Student ID	Grade	Section	Homeroom Teacher
Primary Phone	Date of Birth	**GRADES 6–12 ONLY** YRBS/YTS (see reverse) ❏ May **NOT** Participate	**GRADES 11 AND 12 ONLY** ❏ Do Not Release Contact Information to Military Recruiters.
Home Address		Language Spoken at Home	Preferred Language for Correspondence ❏ English ❏ Chinese ❏ French ❏ Korean ❏ Spanish ❏ Vietnamese ❏ Amharic
Bus Route #	Custody Concerns ❏ Yes ❏ No (If yes, Contact School)		

Is the student a dependent of a member of the active duty forces (full-time) Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or Reserve Forces (Army, Army National Guard of the U.S., Air National Guard of the U.S., Navy, Air Force, Marine Corps, or Coast Guard)? ❏ Yes ❏ No

Name of Responsible Adult Living at Student's Home Address Noted Above. (Last, First, MI) (Contact First)		Name of Responsible Adult Living at Student's Home Address Noted Above. (Last, First, MI)	
Work Phone	Cell Phone	Work Phone	Cell Phone
E-mail		E-mail	
Relationship to Student ❏ Mother ❏ Father ❏ Guardian ❏ Other (Specify)		Relationship to Student ❏ Mother ❏ Father ❏ Guardian ❏ Other (Specify)	

Name of Responsible Adult **NOT** Living at Student's Home Address Noted Above. (Last, First, MI)		Name of Responsible Adult **NOT** Living at Student's Home Address Noted Above. (Last, First, MI)	
Home Address of this Adult		Home Address of this Adult	
Work Phone	Cell Phone	Work Phone	Cell Phone
Home Phone	E-mail	Home Phone	E-mail
Relationship to Student ❏ Mother ❏ Father ❏ Guardian ❏ Other (Specify)		Relationship to Student ❏ Mother ❏ Father ❏ Guardian ❏ Other (Specify)	

Person/Organization Responsible for Student **Before School**—Name (Last, First) (If other than responsible adults noted above)		
Address		
Home Phone	Cell Phone	E-mail
Work Phone	Relationship to Student (if any)	
Person/Organization Responsible for Student **After School**—Name (Last, First) (If other than responsible adults noted above)		
Address		
Home Phone	Cell Phone	E-mail
Work Phone	Relationship to Student (if any)	

Emergency Contacts: In an emergency that requires the school to release student using parent/child reunification protocols, and when responsible adult(s) already listed cannot be reached, the school may release the student to these individuals.

Emergency Contact #1: (Last, First)			Relationship to Student
Home Phone	Cell Phone	Work Phone	E-mail
Emergency Contact #2: (Last, First)			Relationship to Student
Home Phone	Cell Phone	Work Phone	E-mail
Emergency Contact #3: (Last, First)			Relationship to Student
Home Phone	Cell Phone	Work Phone	E-mail

continued on page 2

Physician/Authorized Health Care Provider Name		Physician/Authorized Health Care Provider Phone
Dentist/Hygienist Name		Dentist/Hygienist Phone
Hospital Preference		
Health Insurance ❑ Yes ❑ No (If yes, check one) ❑ Private ❑ Health Choice (Medical Assistance) ❑ Care for Kids		
School officials will administer first aid and/or take your child to a physician or hospital for emergency treatment in the event it appears necessary and responsible adults noted above cannot be contacted. (The rescue squad will be used as deemed necessary in emergency situations.)		
Does the student have an allergy to bee stings? ❑ Yes ❑ No (If yes, please provide additional information such as reaction description, medication, etc.)		
Does the student have an allergy to any foods and/or medications? ❑ Yes ❑ No (If yes, please provide additional information such as reaction description, medication, etc.)		
Does the student have any other allergies? ❑ Yes ❑ No (If yes, please provide additional information such as allergen, reaction description, medication, etc.)		
Does student self-carry an Epinephrine Auto-Injector? ❑ Yes ❑ No (If yes, MCPS Form 525-14 must be completed and returned to the school)		
Does student self-carry any other emergency medication (e.g., Asthma Inhaler)? ❑ Yes ❑ No (If yes, MCPS Form 525-13 must be completed and returned to the school)		
Are there any other medical considerations that you would like to share regarding this student? (e.g., Asthma or Breathing problems, Diabetes, Seizures, or other problem?) ❑ Yes ❑ No If yes (Specify)		
Does the student have a health condition requiring possible emergency care? ❑ Yes ❑ No If yes (Specify)		
Currently prescribed medications (Optional)		
Is medication or a treatment (tube feeding or catheterization) being administered by school staff on a continuing basis, daily, or as needed? ❑ Yes ❑ No (If yes, MCPS Form 525-12, 525-13 *OR* MCPS Form 525-14 must be completed and returned to the school)		
Printed Parent/Guardian Name	Signature of Parent/Guardian	Date

For Students in Grades 6 through 12 ONLY

Information to Parents/Guardians of Middle School and High School Students Regarding the Maryland Youth Risk Behavior Survey/Youth Tobacco Survey

This section of the form is to notify you about the Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) and procedures to follow if you **DO NOT** want your child to participate in the YRBS/YTS.

Your child's school may be taking part in the YRBS/YTS, conducted by the Maryland Department of Health (MDH) in collaboration with the Maryland State Department of Education (MSDE) and the Centers for Disease Control and Prevention (CDC). The survey was designed by the CDC to identify risk behaviors that may include safety behaviors such as use of helmets and seat belts, depression and mental health; use of tobacco, alcohol, or other drugs; nutrition and physical activity; and sexual behavior.

The survey has been designed to protect your child's privacy. The survey is confidential and **students will not put their names on the survey**. No school or student will ever be mentioned by name in a report of the results.

The survey is voluntary. If your child is not comfortable answering a question, your child may skip it. No action will be taken against the school, you, or your child, if your child does not take part. In addition, students may stop participating in the survey at any point without penalty.

If you have any questions about your child's rights as a participant in this survey, or if you feel your child will be harmed in any way by taking part, please call toll-free 1-877-878-3935, leave a message including your name and phone number, and someone will call you back as soon as possible. For more information about the survey, please visit *www.cdc.gov/HealthyYouth/*.

If you DO NOT want your child to take part in the survey, (1) please complete the section on the front of the form which indicates "YRBS/YTS—May Not Participate," (2) return your child's Student Emergency Information form to your child's school.

FREQUENTLY ASKED QUESTIONS

Q. Why is the Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) conducted?
A. The MDH and the MSDE will use the results from the YRBS/YTS to (1) monitor how priority health risk behaviors among middle and high school students change over time; (2) evaluate the impact of broad state and local efforts to prevent health risk behaviors; and (3) improve school health education policies and programs.

Q. Are sensitive questions asked?
A. Some questions may be considered sensitive by some districts, schools, or parents/guardians. All such questions are presented in a straightforward and sensitive manner and were designed by the CDC. Topic areas covered include use of helmets and seat belts; depression and mental health; use of tobacco, alcohol, other drugs, nutrition and physical activity; and sexual behavior.

Q. Will student names be used or linked to the surveys?
A. No. The survey is designed to protect your child's privacy. The survey is administered by specially trained field staff. Students do not put their name on the survey. When students finish the survey, they place the completed survey in a large box or envelope.

Q. Are students tracked over time to see how their behavior changes?
A. No. Students who participate cannot be tracked because no identifying information is collected.

Q. How are children picked to be in the survey?
A. Statewide, approximately 360 schools and 85,000 students are picked to take part. First schools are randomly picked, and then classrooms in selected schools are randomly picked. Every student in a selected class may participate.

Dental Health Form

Montgomery County Department of Health and Human Services
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20850

MCPS Form 525-17
January 2017

INSTRUCTIONS: School health professionals review student health information, including dental health, when students enroll in school. When health problems are identified, school health professionals assist students and parents/guardians in accessing appropriate health services, including dental care.

Please complete Section I of this form and ask your child's dentist or dental hygienist to complete and sign Section II of this form. Return the completed form to the health room at your child's school.

Help in locating a dentist/dental hygienist may be obtained by contacting the Maryland State Dental Association at www.msda.com. If you do not have access to dental care, please contact the school nurse in your child's school.

SECTION I: To be completed by Parent/Guardian

Name of Student	Student ID	
Name of School	Date of Birth	Grade

SECTION II: To be completed by the Dental office.

This is to certify that I have examined the teeth of ______________________________

and:

- ❏ All necessary dental work has been completed.
- ❏ Treatment is in progress.
- ❏ No dental work is necessary.

Further recommendations______________________________

____

____

Name of Dentist/Dental Hygienist	Telephone
Signature of Dentist/Dental Hygienist	Date Signed
Address	Fax Number

PLEASE RETURN THIS FORM TO THE HEALTH ROOM AT YOUR CHILD'S SCHOOL.

MARYLAND DEPARTMENT OF HEALTH 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 IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	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
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
______	______	______	______
______	______	______	______
______			

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 AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME__________________________/____________________/____________________
LAST FIRST MIDDLE

CHILD'S ADDRESS__________________________/______________/__________/__________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE_____/_____/______ PHONE ________________

PARENT OR GUARDIAN __________________________/____________________/____________________
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO

Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO

Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): ____________________ **Signature**: __________________________ **Date**: ____________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: ________________________________ Signature:____

Date:________________________________ Phone: ____________________________

Office Address: ____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): ________________________ Signature: __________________________ Date: __________

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: ________________________________ Signature:____

Date:________________________________ Phone: ____________________________

Office Address: ____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form 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.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

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

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
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

Frederick (Continued)
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

Prince George's (Continued)
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

Queen Anne's (Continued)
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

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.