PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name:	SINGH (Last)	IQBAL (First)	(Middle)	**Birth date:** 03/04/2018 (Mo / Day / Yr)	**Sex** M☒F☐
Address:	17907 COACHMANS RD, GERMANTOWN,MD,20874 (Number Street)		(Apt# City)	(State)	(Zip)

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
NAVDEEP SINGH	FATHER	W: 703-864-0298	C: 703-864-0298	H: 703-864-0298
RAMANDEEP KAUR	MOTHER	W: 703-863-4843	C: 703-863-4843	H: 703-863-4843

Your Child's Routine Medical Care Provider **Name:** Dr. SANGEETHA VIMAL **Address:** 20400, OBSERVATION DR, UNIT 205, GERMANTOWN, MD, 20876 **Phone #** 301-972-9559	**Your Child's Routine Dental Care Provider** **Name:** Dr. Jasmin **Address:** 5732, Buckeystown Pike,Fredrick, Md,21704 **Phone**	**Last Time Child Seen for** **Physical Exam:** 04/04/202 **Dental Care:** 07/01/2021 **Any Specialist :**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☒	
Allergies (Seasonal)	☐	☒	
Asthma or Breathing	☐	☒	
Behavioral or Emotional	☐	☒	
Birth Defect(s)	☐	☒	
Bladder	☐	☒	
Bleeding	☐	☒	
Bowels	☐	☒	
Cerebral Palsy	☐	☒	
Coughing	☐	☒	
Communication	☐	☒	
Developmental Delay	☐	☒	
Diabetes	☐	☒	
Ears or Deafness	☐	☒	
Eyes or Vision	☐	☒	
Feeding	☐	☒	
Head Injury	☐	☒	
Heart	☐	☒	
Hospitalization (When, Where)	☐	☒	
Lead Poison/Exposure complete DHMH4620	☐	☒	
Life Threatening Allergic Reactions	☐	☒	
Limits on Physical Activity	☐	☒	
Meningitis	☐	☒	
Mobility-Assistive Devices if any	☐	☒	
Prematurity	☐	☒	
Seizures	☐	☒	
Sickle Cell Disease	☐	☒	
Speech/Language	☐	☒	
Surgery	☐	☒	
Other	☐	☒	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☒ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☒ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☒ No ☐ Yes, what procedure(s):

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 NEEDS IN CHILD CARE.

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

RAMANDEEP KAUR — Signature of Parent/Guardian

7/9/2021 — Date

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 SINGH (LAST) / IQBAL (FIRST) / (MIDDLE)

CHILD'S ADDRESS 17907, COACHMANS RD, GERMANTOWN, MD, 20874 (STREET ADDRESS with Apartment Number / CITY / STATE / ZIP)

SEX: ☒ Male ☐ Female BIRTHDATE 03 / 04 / 2018 PHONE 703-864-0298

PARENT OR GUARDIAN SINGH (LAST) / NAVDEEP (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): NAVDEEEP SINGH **Signature**: NAVDEEP SINGH **Date**: 7/9/2021

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: _____

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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: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name:	SINGH (Last)	IQBAL (First)	(Middle)	Birth Date: 3/4/2018 (Month / Day / Year)	Sex M☒ F☐

1. Does the child named above have a diagnosed medical condition?
☑ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
☑ No ☐ Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☑	☐	☐	Lead Exposure/Elevated Lead	☑	☐	☐
Behavior/Adjustment	☑	☐	☐	Mobility	☑	☐	☐
Bowel/Bladder	☑	☐	☐	Musculoskeletal/orthopedic	☑	☐	☐
Cardiac/murmur	☑	☐	☐	Neurological	☑	☐	☐
Dental	☑	☐	☐	Nutrition	☑	☐	☐
Development	☑	☐	☐	Physical Illness/Impairment	☑	☐	☐
Endocrine	☑	☐	☐	Psychosocial	☑	☐	☐
ENT	☑	☐	☐	Respiratory	☑	☐	☐
GI	☑	☐	☐	Skin	☑	☐	☐
GU	☑	☐	☐	Speech/Language	☑	☐	☐
Hearing	☑	☐	☐	Vision	☑	☐	☐
Immunodeficiency	☑	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

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. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature: _____ Date: _____

5. Is the child on medication?
☑ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?
☑ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure	80/34	A P: 117	05/20/2021	
Height	3ft 3in			
Weight	28 lb			
BMI %tile				
LeadTest Indicated: DHMH 4620 ☐ Yes ☐ No	Test #1	Test#2	Test # 1	Test #2

Iqbal Singh **has had a complete physical examination and any concerns have been noted above.**
(Child's Name)

Additional Comments: MILESTONE PEDIATRICS, PA
~~20400 OBSERVATION DRIVE~~
SUITE 205
GERMANTOWN, MD 20876

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
Sangeetha Vimal MD	3019722 ext 1359		7/13/2021