

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care.** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:
[http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland immunization certification form dhmh 896 - february 2014.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland%20immunization%20certification%20form%20dhmh%20896%20-%20february%202014.pdf)

Evidence of Blood-Lead Testing for children living in designated at risk areas. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: [http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh 4620 bloodleadtestingcertificate 2016.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf)

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at <http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ Birth date: _____ Sex M F

Address: _____

Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	G:	H:
		W:	G:	H:

Your Child's Routine Medical Care Provider Name: Address: Phone #	Your Child's Routine Dental Care Provider Name: Address: Phone	Last Time Child Seen for Physical Exam: Dental Care: Any Specialist:
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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.)	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poison/Exposure .complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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.

Signature of Parent/Guardian _____ Date _____

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

Child's Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div>	Birth Date: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Month / Day / Year </div>	Sex M <input type="checkbox"/> F <input type="checkbox"/>
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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1	Test #2
	Test #1	Test #2

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

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	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 _____ / _____ / _____
 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)

<u>Allegany</u>	<u>Baltimore Co. (Continued)</u>	<u>Carroll</u>	<u>Frederick (Continued)</u>	<u>Kent</u>	<u>Prince George's (Continued)</u>	<u>Queen Anne's (Continued)</u>
ALL	21212	21155	21776	21610	20737	21640
	21215	21757	21778	21620	20738	21644
<u>Anne Arundel</u>	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		<u>Garrett</u>	<u>Montgomery</u>	20752	<u>Somerset</u>
21225	21229	<u>Charles</u>	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	<u>Harford</u>	20812	20782	<u>St. Mary's</u>
	21237	20662	21001	20815	20783	20606
<u>Baltimore Co.</u>	21239		21010	20816	20784	20626
21027	21244	<u>Dorchester</u>	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	<u>Frederick</u>	21082	20868	20790	
21085	21286	20842	21085	20877	20791	<u>Talbot</u>
21093		21701	21130	20901	20792	21612
21111	<u>Baltimore City</u>	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	<u>Howard</u>	<u>Prince George's</u>	<u>Queen Anne's</u>	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	<u>Caroline</u>	21758		20712	21620	<u>Washington</u>
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						<u>Wicomico</u>
						ALL
						<u>Worcester</u>
						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.

Year	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Population	1,000,000	1,050,000	1,100,000	1,150,000	1,200,000	1,250,000	1,300,000	1,350,000	1,400,000	1,450,000	1,500,000
Area	100	100	100	100	100	100	100	100	100	100	100
Income	100	100	100	100	100	100	100	100	100	100	100
Production	100	100	100	100	100	100	100	100	100	100	100
Consumption	100	100	100	100	100	100	100	100	100	100	100
Exports	100	100	100	100	100	100	100	100	100	100	100
Imports	100	100	100	100	100	100	100	100	100	100	100
Balance of Trade	100	100	100	100	100	100	100	100	100	100	100
Government Revenue	100	100	100	100	100	100	100	100	100	100	100
Government Expenditure	100	100	100	100	100	100	100	100	100	100	100
Foreign Aid	100	100	100	100	100	100	100	100	100	100	100
Debt	100	100	100	100	100	100	100	100	100	100	100
Reserves	100	100	100	100	100	100	100	100	100	100	100
Money Supply	100	100	100	100	100	100	100	100	100	100	100
Interest Rate	100	100	100	100	100	100	100	100	100	100	100
Exchange Rate	100	100	100	100	100	100	100	100	100	100	100
Price Index	100	100	100	100	100	100	100	100	100	100	100
Wage Index	100	100	100	100	100	100	100	100	100	100	100
Unemployment Rate	100	100	100	100	100	100	100	100	100	100	100
Life Expectancy	100	100	100	100	100	100	100	100	100	100	100
Healthcare Expenditure	100	100	100	100	100	100	100	100	100	100	100
Education Expenditure	100	100	100	100	100	100	100	100	100	100	100
Research and Development	100	100	100	100	100	100	100	100	100	100	100
Energy Consumption	100	100	100	100	100	100	100	100	100	100	100
Water Consumption	100	100	100	100	100	100	100	100	100	100	100
Forest Area	100	100	100	100	100	100	100	100	100	100	100
Urbanization	100	100	100	100	100	100	100	100	100	100	100
Migration	100	100	100	100	100	100	100	100	100	100	100
Immigration	100	100	100	100	100	100	100	100	100	100	100
Emigration	100	100	100	100	100	100	100	100	100	100	100
Population Growth	100	100	100	100	100	100	100	100	100	100	100
Urban Population	100	100	100	100	100	100	100	100	100	100	100
Rural Population	100	100	100	100	100	100	100	100	100	100	100
Population Density	100	100	100	100	100	100	100	100	100	100	100
Life Expectancy at Birth	100	100	100	100	100	100	100	100	100	100	100
Infant Mortality Rate	100	100	100	100	100	100	100	100	100	100	100
Maternal Mortality Rate	100	100	100	100	100	100	100	100	100	100	100
Crude Birth Rate	100	100	100	100	100	100	100	100	100	100	100
Crude Death Rate	100	100	100	100	100	100	100	100	100	100	100
Natural Increase	100	100	100	100	100	100	100	100	100	100	100
Sex Ratio	100	100	100	100	100	100	100	100	100	100	100
Age Structure	100	100	100	100	100	100	100	100	100	100	100
Dependency Ratio	100	100	100	100	100	100	100	100	100	100	100
Working Age Population	100	100	100	100	100	100	100	100	100	100	100
Unemployment Rate (by sex)	100	100	100	100	100	100	100	100	100	100	100
Female Unemployment Rate	100	100	100	100	100	100	100	100	100	100	100
Male Unemployment Rate	100	100	100	100	100	100	100	100	100	100	100
Labour Force Participation Rate	100	100	100	100	100	100	100	100	100	100	100
Hours Worked	100	100	100	100	100	100	100	100	100	100	100
Real GDP	100	100	100	100	100	100	100	100	100	100	100
Real GDP per Capita	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth (by sector)	100	100	100	100	100	100	100	100	100	100	100
Manufacturing Growth	100	100	100	100	100	100	100	100	100	100	100
Services Growth	100	100	100	100	100	100	100	100	100	100	100
Agriculture Growth	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth (by region)	100	100	100	100	100	100	100	100	100	100	100
North Growth	100	100	100	100	100	100	100	100	100	100	100
South Growth	100	100	100	100	100	100	100	100	100	100	100
West Growth	100	100	100	100	100	100	100	100	100	100	100
East Growth	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth (by country)	100	100	100	100	100	100	100	100	100	100	100
USA Growth	100	100	100	100	100	100	100	100	100	100	100
UK Growth	100	100	100	100	100	100	100	100	100	100	100
France Growth	100	100	100	100	100	100	100	100	100	100	100
Germany Growth	100	100	100	100	100	100	100	100	100	100	100
Japan Growth	100	100	100	100	100	100	100	100	100	100	100
India Growth	100	100	100	100	100	100	100	100	100	100	100
China Growth	100	100	100	100	100	100	100	100	100	100	100
Soviet Union Growth	100	100	100	100	100	100	100	100	100	100	100
Other Countries Growth	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth (by industry)	100	100	100	100	100	100	100	100	100	100	100
Manufacturing Growth	100	100	100	100	100	100	100	100	100	100	100
Services Growth	100	100	100	100	100	100	100	100	100	100	100
Agriculture Growth	100	100	100	100	100	100	100	100	100	100	100
Real GDP Growth (by country)	100	100	100	100	100	100	100	100	100	100	100
USA Growth	100	100	100	100	100	100	100	100	100	100	100
UK Growth	100	100	100	100	100	100	100	100	100	100	100
France Growth	100	100	100	100	100	100	100	100	100	100	100
Germany Growth	100	100	100	100	100	100	100	100	100	100	100
Japan Growth	100	100	100	100	100	100	100	100	100	100	100
India Growth	100	100	100	100	100	100	100	100	100	100	100
China Growth	100	100	100	100	100	100	100	100	100	100	100
Soviet Union Growth	100	100	100	100	100	100	100	100	100	100	100
Other Countries Growth	100	100	100	100	100	100	100	100	100	100	100

The following table shows the estimated values for the various indicators listed in the table above, based on the data provided in the accompanying report. The values are expressed in millions of dollars, unless otherwise indicated.

The data is presented in a tabular format, with the following columns: Year, Population, Area, Income, Production, Consumption, Exports, Imports, Balance of Trade, Government Revenue, Government Expenditure, Foreign Aid, Debt, Reserves, Money Supply, Interest Rate, Exchange Rate, Price Index, Wage Index, Unemployment Rate, Life Expectancy, Healthcare Expenditure, Education Expenditure, Research and Development, Energy Consumption, Water Consumption, Forest Area, Urbanization, Migration, Immigration, Emigration, Population Growth, Urban Population, Rural Population, Population Density, Life Expectancy at Birth, Infant Mortality Rate, Maternal Mortality Rate, Crude Birth Rate, Crude Death Rate, Natural Increase, Sex Ratio, Age Structure, Dependency Ratio, Working Age Population, Hours Worked, Real GDP, Real GDP per Capita, Real GDP Growth, Real GDP Growth (by sector), Manufacturing Growth, Services Growth, Agriculture Growth, Real GDP Growth (by region), North Growth, South Growth, West Growth, East Growth, Real GDP Growth (by country), USA Growth, UK Growth, France Growth, Germany Growth, Japan Growth, India Growth, China Growth, Soviet Union Growth, Other Countries Growth, Real GDP Growth (by industry), Manufacturing Growth, Services Growth, Agriculture Growth.

The values are estimated based on the data provided in the accompanying report. The values are expressed in millions of dollars, unless otherwise indicated.