KINGDOM KARE CHILDCARE CENTER
ADMISSION PACKET

“Taking Care of Your Children God’s Way”

“For I know the plans I have for you declares the Lord, plans to prosper you and not to harm you, plans to give you a hope and a future.” Jeremiah 29:11

Kingdom Kare Childcare Center does not discriminate on the basis of a person’s religion, race, color, gender, age, national origin, disability, family structure, sex, gender identity, sexual orientation, Vietnam-era status, or any other factors protected by law.

Kingdom Kare Childcare Center does not discriminate and is inclusive of children with disabilities or special health care needs.

Dear Parents,

Welcome to Kingdom Kare Childcare center! We understand that for some of you, this is a new walk and for others you have experienced working with a childcare center before. Either way, we are here to ensure that we provide you the experience of a high-quality early childhood education program.

Philosophy of Education:

Kingdom Kare Childcare Center is a ministry of Kingdom Celebration Center and its philosophy is consistent with the philosophy, goals, and objectives of the church.

"Taking care of your children God's way"

Mission

Kingdom Kare Inc. is a non-profit (501 C 3) whose mission is to nurture children and their families, so they feel empowered to pursue their dreams. We do this by focusing our attention in three areas: Early Childhood Education, Mentoring and Family Support.

Early Childhood Education: Childcare center that serves children ages 0-5 years old, with a component for before and after care for children ages 6-12 years old.

Mentoring: We offer after-school intervention programs at two middle schools in Anne Arundel County for students with demonstrated academic, social, and behavioral challenges.

Family Support Center: The overall goal and mission of the Family Support Center is to provide prevention-oriented programs to strengthen families in the Northern and Western corridors in Anne Arundel county. The center will focus on child-centered, family-focused programs that serve parents and their children, age six weeks - three years. All families will be treated equally, regardless of their race, color, religion, sex, national origin, disability, or any other basis prohibited by law. All programs, privileges, rights, and activities are made regardless of income or marital status, race or religion, degree of need or any other stigmatizing factors, will be served.

The wide range of programs listed below includes the core services and have been expanded to serve the entire family unit:

● Child Development	● Home Visiting
● Adult Education	● Life Skills Education
● Teen Parent Alternative Program	● English as a Second Language (ESL)
● Employment Readiness	● Parenting Education

2 Week Trial Period:
Not only are you interviewing us, but we are interviewing you, and in an effort to ensure that Kingdom Kare is a good fit for your family, and that your family is a good fit for us, we have a 2-week trial period. At the conclusion of your 2-week trial, if Kingdom Kare decides that you are not a good fit for us, a member of the administrative team will meet with you to discuss further steps.

Please read the following information about our Policies, Rates, and Hours of Operation. A comprehensive parent handbook will be distributed upon acceptance at Kingdom Kare. We require that you sign a receipt for this information so that we know you have had an opportunity to read, understand and agree to the terms and conditions prior to your child entering Kingdom Kare. Please return this signed form prior to your child starting his/her enrollment.

Policies and Procedures
All required physicals, emergency data and other forms required by the Office of Licensing of Child Care Administration and Kingdom Kare must be completed and accompanied by the registration fee and security deposit prior to your child's attendance at the center. These forms then become the property of the center and must be retained for a period of two years. We will provide copies upon request providing two (2) weeks advance notice of intention to withdraw has been given in writing to the Director of Programs, AND tuition is paid up to date. Withdrawal without the above written notice requires payment of two (2) weeks additional tuition (at the weekly rate in effect at the time of withdrawal) beyond the withdrawal date for staffing requirements and other considerations. Once admission has been confirmed by acceptance of the registration fee, this fee is no longer refundable.

Our hours of operation are Monday-Friday, 6:00am-5:00pm.

Thank you and blessings!

FAQ:
Hours of operation: Monday-Friday 6:00am-5:00pm. Kingdom Kare Childcare Center has scheduled drop off times between the hours of 6am and 8am. Please discuss desired drop off time with the Director before enrollment. Between the hours of 8am and 9:30am, there is an open drop off window where children without scheduled times can be dropped off at any time between these times.
What is the drop-off/pick-up procedures? When dropping off or picking up please remember to sign your child in/out at the table located in the lobby and proceed to your child's classroom. For the health and safety of the children in our care we ask that parents drop off at the classroom door only.
Does Kingdom Kare have a handbook with polices concerning sick, vacation, and payments? Yes, a copy of the Parent Handbook will be emailed to you within 3 days of enrollment.
When is tuition due? Tuition is due each Monday by 5pm. If payment is not received by that time, your account will be charged a $35.00 late fee.
Can I make payments on-line? Yes, please reach out to our Director of Programs (Kimberly Curtis) for information on making on-line payments.

What happens if I arrive after 5pm? A late fee of $3 per minute past 5pm will be charged which must be paid at the time of pick up.

Is tuition still owed if the center closes early or closes for holidays? The full tuition amount is the same even when Kingdom Kare is closed.

Who should I contact with questions? Kingdom Kare is unique in that we have several staff who supervise our program. Any of the following staff are here to support you!

Barbara Palmer, Executive Director
Kimberly Curtis, Director of Programs
Diminkga Grannum, Director of Early Childhood Education

PAYMENT STRUCTURE

The current fee structure is attached and is a part of the contract agreed to by the parent or guardian. All fees and payments are due on **Monday** of the week of service. Any payments received after 5:00PM Monday must be accompanied by the late payment fee of $35.00. This WILL BE STRICTLY ENFORCED. If payments are not received by Friday of the week of service, your child may be subject to termination of care and an additional fee of $35.00 will be charged.

Security Deposit

Kingdom Kare requires a security deposit due at the time of initial registration to secure a childcare space. The security deposit is equivalent to one-weeks tuition. Prior to your child beginning care, the security deposit is not refundable. The security deposit will be held until Kingdom Kare is given a two-week written notice of withdrawal. When your account is current at the time of your child's withdrawal, the security deposit will be refunded in full. Any outstanding tuition balances will be deducted from the security deposit and the remaining security balance will be refunded. No interest will be accumulated on the security deposit. An agreement will be signed at the time of a child's initial registration regarding the security deposit.

Registration fee per child: $100.00 (non-refundable, one-time fee).

Please note that the registration fee for any student on the Enrollment Roster must be made via money order, credit card, or cash.

Tuition and Fees

$412.00 (Infants and Toddlers 0-23 months)
$335.00 (2-years-old)
$276.60 (3-4-years-old)

LEGAL RECOURSE

LEGAL RECOURSE

Should civil action be required to recover any monies due to Kingdom Kare, the cost of such civil action, including but not limited to the serving of papers, court costs, and attorney fees shall be borne by the parent or guardian owning such monies, including 15% interest on all awarded amounts.

Subsidy/Vouchers-Social Service:

Kingdom Kare accepts Child Care Aware and Department of Social Services vouchers to enroll your child and they must be presented and approved in advance of registration. Families who receive Child Care Aware and Social Service assistance are responsible for payment of all fees not covered by Child Care Aware or Social Services, including tuition. The co-payment, late fees, returned check fees, registration and re registration fees shall be paid within ten (10) days of receipt of invoice. Parents are responsible for full tuition until payment is received by Child Care Aware or DSS. When Kingdom Kare receives the payment from Child Care Aware or DSS, the amount will be credited to the tuition account.

Binding Contract:

This constitutes a contract on the part of the below acknowledged parent or guardian with Kingdom Kare. In the event of litigation to recover any monies due Kingdom Kare, the parent or guardian agrees that all cost of such litigation shall be borne by the parent or guardian.

Parent/Guardian Signature: _____

Date signed: _____

Acceptance by Parent or Guardian.

I have been given a copy of this contract and current fee structure, have had opportunity to read them and have my questions answered, and I fully understand the terms and conditions.

_____ _____

Parent/Guardian Name Date

_____

Child's / Children's Name(s)

In case of emergency and my child must be transported to a hospital, I understand that my child will be transported to the nearest available hospital. I give consent for a Kingdom Kare staff member to go with my child for a medical emergency.

I further understand that all records will be kept in a locked file cabinet and can only be viewed by the administrative team.

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF KINGDOM KARE POLICES AND TERMS

I have received a copy of the Parent Handbook explaining the policies, procedures, fee structure, dietary guidelines, and hours of operation of Kingdom Kare Child Care Center.

I have had an opportunity to read this information, have my questions answered and understand the various policies contained herein.

I accept these conditions and agree to enroll my child/children at Kingdom Kare.

_____ _____

Date Parent/Guardian

_____

Name of Child

Please sign and date after reading. Please return this sheet with all other required forms

Kingdom Kare Childcare Center
Permit/License Number: 161267

Attention Parent and/or Guardian: **COLLECTION EFFORTS**

I understand if I have an unpaid balance to Kingdom Kare and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Kingdom Kare or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Kingdom Kare and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

The intent of this notice is to inform you that Kingdom Kare Childcare Center is a member of the Payment Violators Network. As part of your enrollment with the above named childcare facility, you are hereby notified that this facility subscribes to Payment Violators.

The Payment Violators Network is essentially a childcare database and network that allows all childcare providers throughout United States and Canada, to communicate and share payment history of parents and/or guardians that leave a facility in breach of the Permit holder's payment policy This is to include, but not limited to, giving the required notice prior to discontinuing your enrollment, late payments, and nonpayment. Licensed Child Center Advocacy Group Inc., in the event of any breach of contract, will represent Kingdom Kare Childcare Center in an attempt to collect on all delinquent accounts.

The collection attempts will range from phone calls, legal letters of request, and ultimately if all requests for delinquent payments are unsuccessful, Licensed Child Center Advocacy Group Inc., will report all unpaid collection accounts with all major credit bureaus. This will become a record on the violator's credit history. Please understand that all violators will be entered into the database for all childcare providers throughout the US and Canada to view. This could have a major negative impact on your ability to receive childcare services in the future.

By signing this agreement, you certify that you have read and understand the full intent of this agreement. Your refusal to sign this agreement does not mean you will not be subjected to all collection activity and consequences as mentioned above, in the event of a breach of contract and no- payments.

Parent/Guardian Signature: _____
Date signed: _____

Director/Permit Holder Signature: _____
Date signed: _____

STUDENT REGISTRATION FORM

Please print or type all information requested. State regulations require that all paperwork must be completed on each child **before they can attend.**

Child's Name:_____
Last First Middle Nickname

Date of Birth: _____ **Age at Enrollment:** _____ **Gender (circle one): Male / Female**

Anticipated Days of Attendance: **Desired Start Date:** _____

☐ **Full Time**: Monday – Friday

Please Note: Drop off times between 6:00am- 8:00am are scheduled and require approval.

Scheduled Drop off Time: _____ **Time Anticipated Departure Time**: _____

Parent / Guardian Name:

Last_____ First _____ Middle _____

Address _____

City_____ State_____ Zip _____

Home Phone _____ Work Phone_____Cell Phone _____

Email _____ Employer_____

Employer Address _____

Parent / Guardian Name:

Last_____ First _____ Middle _____

Address _____

City_____ State_____ Zip _____

Home Phone_____ Work Phone_____Cell Phone _____

Email_____ Employer_____

Employer Address _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Child Resides With: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian

☐ Other (Please specify): _____

***If custody agreements/arrangements are applicable, please attached court ordered documentation*)**

Children with Special Needs/Individualized Family Service Plan/Individualized Education Plan

Kingdom Kare Childcare Center does not discriminate and is inclusive of children with disabilities or special health care needs.

As partners in your child's education Kingdom Kare Childcare Center request that parents share documents pertaining to your child's IFSP/IEP that relates to how staff can work with the child in partnership with the family and other service providers to assist in the child's overall development. Because the IFSP/IEP may contain information that parents feel is private, the parents may wish to have some portions of the IFSP/IEP remain confidential.

I agree to share my child's documents with Kingdom Kare Childcare Center as it pertains to my child special needs in order to assist with the overall development of my child. _____ Initial

Children Transport to and from evacuation sites in case of emergency

In the event of an emergency, I give Kingdom Kare Childcare Center permission to transport my child in company vehicles and personal vehicles if necessary to and from our designated evacuation site. _____ Initial
If not, how would you like your child transported? _____

I, therefore, acknowledge that I have received an overview of Kingdom Kare Childcare Center's Emergency Preparedness Plan. _____ Initial

My child has permission to go on walks on the Kingdom Kare & Family Support Center property. _____ Initial

I understand that a PARENT ORIENTATION is required prior to my child's first day of attendance. _____ Initial

I understand that children who have chronically poor behavior may be suspended or dismissed from the program. _____ Initial

I understand that EMAIL is an important source of communication from Kingdom Kare and its representatives, and I AGREE to read emails in their entirety regularly. _____ Initial

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date:_____

For Office Use Only ☐ Security Deposit ☐ Added to ProCare ☐ Parent Orientation ☐ Parent Email List
☐ Tuition Express Authorization Form ☐ Tuition Express Registration ☐ Classroom Picture/Documentation
☐ Teacher (All About Me, Emergency Form, Medication Forms, Infant Feeding Plan (if applicable))

STATEMENT OF COOPERATION AND AGREEMENT

Please read initial, sign and date

1. **Registration Requirements:** I understand that Maryland State Department of Education regulations require that every child must be registered before they can attend any childcare center. **Registration will not be complete until ALL forms are filled out, returned, and a parent orientation is conducted. State regulations also require an emergency card, health inventory forms and updated shot records for your child be on file at the center BEFORE he or she begins care.** _____ Initial

2. **Security Deposit:** I understand that the security deposit equal to one week's tuition is due at time of registration and will reserve space for my child at Kingdom Kare. This is a nonrefundable fee. I also understand that the security deposit is applied to last week of tuition when two weeks' notice is given in writing. If two weeks' notice is not given, the security deposit is forfeited _____ Initial

3. **Methods of Payments:** Payments for childcare services are made through our automated payment processing, Tuition Express (*See forms attached*). Your payment processing may be set up through a credit card or bank draft.
   If an automated payment is returned unpaid, a service fee of $35.00 in addition to other amounts due will be applied to your child's tuition account. _____ Initial

4. **Late Payment Penalties:** I understand that tuition is due each Monday to secure my child's spot in the center. I understand that a $35.00 late fee will be assessed to my account if payment is not made by close of business each Monday and an additional late fee will be assessed each week that a payment is not made by the agreed upon date. _____ Initial

5. **Non-Payment of Fees:** I understand that the tuition is not subject to reduction or refund due to absence because of vacations, illness, or whatever reason my child is absent. As well as if the center is closed due to holiday, inclement weather, or other unforeseen circumstances**.** _____ Initial

6. **Insufficient Funds Fee:** I understand that a $35.00 fee will be assessed to my child's account in the event there are insufficient funds available upon the weekly automatic debit transaction from my bank account or credit card. I understand that it will be treated as non-payment and the late fee of $35.00 will also be charged to my account. Your child will not be allowed to return to the center the following week until the past due balance is paid and the next week is paid in full. _____ Initial

7. **Changes in Tuition:** I understand that tuition rates are subject to change, and I agree that I will pay the new rate after the Center gives my family at least thirty (30) days' notice of such change. _____ Initial

8. **Readmission After Illness** State licensing regulations requires that if your child has been ill, he or she may not be readmitted to the Center until he or she is free of symptoms for 24 hours without any fever-reducing medications. You hereby agree to abide by this requirement and agree that the decision of the Center's Director shall govern such a re-admission. _____ Initial

9. **Inclement/Emergency Closings** Kingdom Kare Childcare Center follows the Anne Arundel County Public School's inclement weather delays and closures. Should the school system close or delay opening for inclement weather, Kingdom Kare will follow the same guidance. You are advised to watch and listen to the news for such announcements. _____ Initial

10. **Cell Phones:** We kindly ask that parents refrain from using your cell phone during pick up and drop off. Teachers have limited chances to communicate with you, so we would like you to be available to effectively communicate with them about your child's day. _____ Initial

11. **Babysitting Policy:** Kingdom Kare Childcare Center staff are not allowed to babysit children enrolled in Kingdom Kare Childcare Center outside of business hours. If any staff member goes against this policy, that staff member and that family's care will be terminated immediately. _____ Initial

As a Kingdom Kare family, I commit to carefully read and support all policies as outlined above and in the Parent Handbook that I have received. If I become dissatisfied with Kingdom Kare in anyway, I will seek to resolve the matter with the person or persons involved in a respectful manner. I agree to partner with the teachers and staff of Kingdom Kare to ensure there is communication regarding the care of my child and any concerns that are had by any party.

Parent/Guardian's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

Director's Signature _____ Date _____

KINGDOM KARE Screen Time Policy

Kingdom Kare follows the American Academy of Pediatrics' recommendations in conjunction with the Code of Maryland Regulations as it relates to Child Care Centers on screen time.

Kingdom Kare will use interactive technology to support rather than replace creative play, physical activity, hands-on exploration, outdoor experiences, social interactions, and other developmentally appropriate learning activities for children 2 years old or older. Therefore, we will restrict screen time by:

- Allowing a maximum of 30 minutes total per week of educational and age-appropriate screen time.
    1. An occasional exception to the weekly viewing passive technology viewing limit may be made for a special event or project, including a holiday or birthday celebration, or for educational content that is related to the center's curriculum.
- Allowing no more than 15 minutes of age-appropriate, educational passive technology time per day.
- Not allowing any screen time during meals and snacks.
- Having zero screen time for children under the age of two.

My signature below indicates that I have read and understand the Screen Time policy and I have received a copy of it for my records.

Name _____

Signature _____

Date_____

Permission to Photograph

Today's Date: _____

Kingdom Kare Childcare Center uses photographs of children engaged in classroom and outdoor activities. The use of photographs may also be displayed to promote the Childcare Center. These images may be used in print and digital media which include monthly newsletters, websites, posters, advertising, Kingdom Kare Childcare Center's social media and teaching purposes for the view of prospective clients in brochures and around the center. Children's names are never displayed, only a brief description of the activity and learning domain when applicable.

Please choose your consent option below:

I _____, give permission for Kingdom Kare Childcare Center to photograph my child, _____ for the above stated purposes.

I _____, DO NOT give Kingdom Kare Childcare Center permission to photograph my child, _____.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize Kingdom Kare Childcare Center of the above permissions. I agree that this form will remain in effect during the duration of my child's enrollment.

Signed:_____ Date: _____

Director's Signature: _____ Date: _____

1350 Blair Drive Suite G Odenton, Maryland 21113
T: 410-672-2006

School Calendar Year 2024/25

January 1st (Monday)	Closed	2024 New Year Day
January 15th (Monday)	Closed	Martin Luther King Jr.
January 26th (Friday)	Closed	Teachers In-service
February 19th (Monday)	Closed	Presidents Day
March 29th (Friday)	Closed	Good Friday
April 1st (Monday)	Closed	Easter Monday
April 26th (Friday)	Closed	Teachers In-Service
May 24th (Friday)	Closed	Preschool Graduation
May 27th (Monday)	Closed	Memorial Day
June 19th (Wednesday)	Closed	Juneteenth
July 4th (Thursday)	Closed	Independence Day
July 5th (Friday)	Closed	Teachers In-Service
August 29th -August 30th (Thursday-Friday)	Closed	Professional Development Training
September 2nd (Monday)	Closed	Labor Day
October 3rd (Thursday)	Closed	Rosh Hashanah
October 14th (Monday)	Closed	Indigenous People Day
November 1st (Friday)	Closed	Teachers In-Service
November 5th (Tuesday)	Closed	Election Day
November 11th (Monday)	Closed	Veterans Day
November 27th-November 29th (Wed.-Fri.)	Closed	Thanksgiving Break
December 23rd -December 30th(Mon.-Mon.)	Closed	Christmas/Winter Break
December 31st (Tuesday)	Closed	New Year's Eve
January 1st (Wednesday)	Closed	2025 New Year Day

Childs Name: _____

Parents Signature: _____ Date: _____

Please note: *Kingdom Kare reserves the right to add or change dates with a two week notice to parents.*

KINGDOM KARES CHILDCARE CENTER DISCIPLINE POLICY

At Kingdom Kare we encourage positive redirection. Positive redirection teaches children that limits are set, how to maintain control of their bodies, and how to problem solve in the event of conflict.

We encourage children to empathize with one another's feelings and see the results of their actions. We discourage inappropriate behavior. We also have a "Cool Down" area that children can utilize to help identify what they are feeling and with the help of the teachers, figure out why they are feeling that way as well as how to express their emotions in a healthier way. No child is subjected to corporal punishment or physical discipline at any time. Discipline shall never be related to food, rest, or toileting.

We will make every effort to work with parents of children having difficulties in childcare. Behavior of children which disrupts normal classroom group activities on a frequent or extended basis may indicate physical or emotional problems requiring the attention of a professional specialist. The teacher and/or Director, with parental consent, will take the necessary steps to refer the child to the Public Health Nurse, a Mental Health Consultant, or other appropriate places for a professional evaluation.

Children displaying chronic disruptive behavior which is upsetting to the physical or emotional well-being of another child may require the following actions:

1. Parents of the child will be called in for a conference. We will discuss the issues and identify some possible solutions. A plan of action will be developed and agreed upon by the parents, staff, and a health/behavioral specialist.
2. If the plan of action is not working, the parents will be called in for another meeting. We will discuss what is not working and develop another action plan.
3. If no progress has been made towards solving the problematic behavior, the child may be suspended from care. This suspension may range in length from the rest of the day to indefinitely.

Kingdom Kare Childcare Center reserves the right to cancel the enrollment of a child for the following reasons:

- Physical and/or verbal abuse of staff or children by parent or child
- Not observing the rules of the center as outlined in the handbook and/or parental agreement

The use of physical force as a discipline measure is prohibited. This includes spanking, slapping, pinching, shaking, biting, pulling hair or arms, jerking, etc.

Techniques

In helping to direct the child toward self-discipline, the following guidance techniques are used:

1. Positive statements are used in giving direction to behavior.
2. Redirection is consistent with the child's needs.
3. The child is given opportunities to make choices and solve problems.
4. Suggestions are given in time to prevent conflicts.
5. Comparisons of children are avoided.
6. Unacceptable behavior is clearly explained, and the child is told what is acceptable. Approval of acceptable behavior is clearly expressed.

Responsibility

Discipline of children shall primarily be the responsibility of core classroom staff in accordance with the individual child's age, stage of development, and the knowledge that the teacher has of the child's needs. We also view guidance as a team effort and an ongoing learning process, so feel free to ask for help if you need support in any child guidance situation including with your own child.

Methods

Disciplinary methods used shall be based on guidance to help the child develop inner control, self- responsibility, respect for the rights of others, as he/she learns to cope with the daily experiences of living and working with others. UNDER NO CIRCUMSTANCES WILL CORPORAL PUNISHMENT BE USED OR TOLERATED BY ANYONE ON SITE!! Verbal abuse will not be allowed-this means no yelling, no obscene language and no put downs between adults or between adults and children. Spanking, threatening, and withholding food or outdoor play cannot be used to discipline children.

Respect

The staff shall accept and respect each child for who he/she is as a unique individual. If a child's behavior becomes unacceptable, this shall be explained to the child in a positive way without humiliation, fright, or physical harm. The child will then be instructed in finding a better way of resolving his/her problems or meeting his/her needs. Respect for each child's feelings shall be maintained.

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
ALL ABOUT: _____
Child's First Name or Nickname

Child's Name: _____ Birthdate: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Address: _____ Zip Code: _____

Provider/Center: _____ Phone: _____

Address: _____ Zip Code: _____

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES
MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES
THINGS MY CHILD MIGHT NEED HELP WITH
WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: _____ Date: _____

Provider: _____ Date: _____

Updates:

Parent/Guardian: _____ Date: _____ Parent/Guardian: _____ Date: _____

Provider: _____ Provider: _____

Infant Feeding Plan

Child's Name:	*Date:*	*Birthdate:*

Formula:

☐No ☐Yes Is your child fed formula[1]?

☐No ☐Yes Will formula be prepared (mixed) at home?

☐No ☐Yes Will formula be prepared by the caregiver?

If the caregiver will be preparing the formula, please indicate any special instructions:

_____

Breast Feeding/Breastmilk

☐No ☐Yes Is your child breast fed?

☐No ☐Yes I will nurse my child at the center at these times:

_____

☐No ☐Yes I will provide breast milk[1].

If breast milk is unavailable for a feeding, the center should:

_____

Feedings:

☐No ☐Yes Does your child take a bottle? (Note: Bottles are required to be labeled with child's name and the current date.)

- ☐No ☐Yes Is the bottle warmed[2]?
- ☐No ☐Yes Does your child hold their bottle?
- ☐No ☐Yes Can the child feed his or herself?
- ☐No ☐Yes Are there any special instructions for bottle feeding your child?

If "yes," please explain:

_____

☐No ☐Yes Is your child using a sippy cup? (Note: Sippy cups must be labeled with the child's name.)

☐No ☐Yes Does your child have any problems with feeding, such as choking or spitting up?

If "yes," please explain:

_____

☐No ☐Yes Are there any special instructions concerning feeding your child?

If "yes," please explain:

_____

Foods and Feeding Schedule:

Liquids (formula, breastmilk, 100% fruit juice in a cup)	☐N/A ☐Introducing ☐Familiar	☐Breast Feeding ☐by bottle ☐by breast ☐Bottle Feeding ☐by caregiver ☐with help ☐independently ☐Cup Feeding ☐with help ☐independently		Amounts:
Semisolid Foods (infant cereal, strained fruits and/or vegetables)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Modified Table Foods (mashed, soft, diced fruit and /or vegetables, strained meat or poultry, pieces of soft bread)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Finger Foods (small pieces of soft/cooked table food, chopped food)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:

Other:

☐No ☐Yes Does your child take a pacifier?

Note: Pacifiers with straps or other types of attachment devices are not permitted. Pacifiers must be removed when the child is crawling or walking.

Additional Information:

I will promptly provide any updates to my child's feeding plan as needed.	*PARENT'S SIGNATURE:*	*DATE:*

[1]Breast milk shall be gently mixed but not be shaken. Refrigerated breast milk shall be used within 24 hours. Formula or breast milk that is served, but not completely consumed or refrigerated, shall be discarded. [2] No milk, formula, or breast milk shall be warmed in a microwave oven.

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment:Yes:☐ No:☑

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number

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 IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: _____
LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	_____	DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				_____	_____	_____	_____	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					_____		_____	_____	DOSE #5	DOSE #10

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: _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations**. The immunization certification form (MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old**. The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at:https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620.
- **Medication Administration Authorization Forms**. If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan, contact the local Health Department. Information on how to contact the local Health Department can be found here: https://health.maryland.gov/Pages/Home.aspx#

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program

PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	**Name:**	**Name:**	☐ Yes ☐ No	**Physical Exam:**
Address:	**Address:**	**Address:**	**Child Care Scholarship**	**Dental Care:**
Phone:	**Phone:**	**Phone:**	☐ Yes ☐ No	**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	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Disorder	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

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.

_____
Printed Name and Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Health Care Provider

Child's Name: Last	First	Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

2. Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

3. 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:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Disorder	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. 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).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

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

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)

10. **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

Maryland State Department of Education
Office of Child Care

Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.
Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's Picture Here (optional)

PRESCRIBER'S AUTHORIZATION

Child's Name:_____Date of Birth: ____/_____/_____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from:____/____/_____ to ____/____/_____

If PRN, for what symptoms, how often and how long_____

Possible side effects and special instructions**:**_____

Known Food or Drug Allergies: ☐ Yes ☐No If yes, please explain:_____

For School Age children only: The child may self-carry this medication: ☐ Yes ☐No

The child may self-administer this medication: ☐ Yes ☐No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No**

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date _____ ☐ Yes ☐ No
2. Medication labeled as required by COMAR. ☐ Yes ☐ No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐ No ☐N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐ No ☐N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care
MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				**Date of Birth:**	
Medication Name:				**Dosage:**	
Route:				**Time to Administer:**	
DATE ADMINISTERED	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____	3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐ URI ☐ Seasonal Allergies ☐Pollen ☐ Exercise ☐Animals ☐Dust ☐Smoke ☐ Food ☐Weather ☐Other_____

6. **This authorization is NOT TO EXCEED 1 YEAR FROM_____/_____/_____ TO _____/_____/_____**
FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐Breathing is good ☐No cough or wheeze ☐Can walk, exercise, & play ☐Can sleep all night **If known, peak flow greater than _____ (80% personal best)**					

Exercise Zone ☐ CALL 911 ☐ CALL PARENT ☐ OTHER: _____

☐Prior to all exercise/sports ☐When the child feels they need it	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**

YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has **ANY** of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest ☐Cough or cold symptoms ☐Shortness of breath ☐Other:_____ **If known, peak flow between ____ and _____ (50% to 79% personal best)**					

RED ZONE - MEDICAL ALERT/DANGER ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has **ANY** of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐Breathing hard and fast ☐Lips or fingernails are blue ☐Trouble walking or talking ☐Medicine is not helping (15-20 mins?) ☐Other:_____ **If known, peak flow below _____ (0% to 49% personal best)**					

Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) _____/_____/_____

Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

8. PRESCRIBER'S NAME/TITLE			Place Stamp Here
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: OK to Self-Carry/Self -Administer ☐ Yes ☐ No

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. CELL PHONE #	10e. HOME PHONE #	10f. WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:	1. Medication named above was received Expiration date _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐N/A
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:					**Date of Birth:**	
MEDICATION	**DATE**	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

Maryland State Department of Education
Office of Child Care

Allergy and Anaphylaxis
Medication Administration Authorization Plan

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 to be completed by the Authorized Health Care Provider.
FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

Place Child's Picture Here (optional)

CHILD'S NAME: _____ Date of Birth: ____/_____/_____ **Date of plan**: _____
Child has **Allergy** to _____ ☐Ingestion/Mouth ☐ Inhalation ☐Skin Contact ☐Sting ☐Other_____
Child has had anaphylaxis: ☐ Yes ☐ No
Child has asthma: ☐ Yes ☐ No (If yes, higher chance severe reaction) Child may self-carry medication: ☐ Yes ☐ No
Child may self-administer medication: ☐ Yes ☐ No

Allergy and Anaphylaxis Symptoms	**Treatment Order**	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth ☐ Call Parent ☐ Call 911	Epinephrine(EpiPen) IM Injection in Thigh ☐ Call 911 ☐ Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

1) **Inject epinephrine right away! Note time when epinephrine was administered.**
2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care

Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name:_____ Date of Birth:_____

PARENT/GUARDIAN AUTHORIZATION
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY

Child Care Responsibilities:	1. Medication named above was received	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Card updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐N/A
	6. Individualized Plan: IEP/IFSP	☐ Yes ☐ No ☐N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

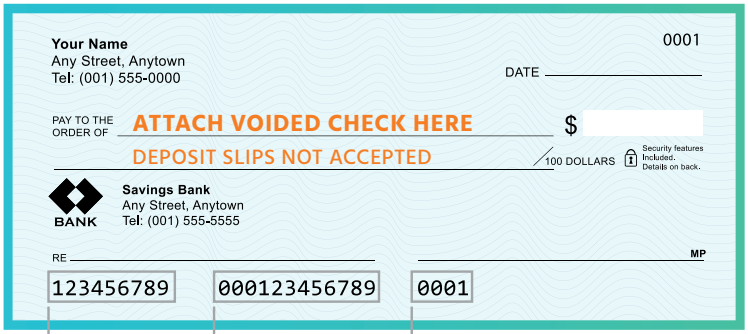
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

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