


Enrollment Application Packet

Child's Name: _____
 Date of Birth: ____/____/____ Class: _____
 Application Date: ____/____/____ Enrollment Date: ____/____/____

Following is a check list for the required forms for your child care provider and State Licensing Regulations. Please use this to help track your progress as you complete these forms. All documents must be returned prior to your child's first day of class. We prefer all documents be kept together and returned at the same time. Upon receipt, we will review your application and confirm your registration date by letter within ten business days.

#	Document Title	
COMPLETED BY PARENT		
1	Check: Deposit Equal to one week's tuition	
2	Check: Application Fee (\$____.00 Single/ \$____.00 Family)	
3	Check: Activity Fee	
4	Center Parent Agreement	
5	Parent Enrollment Form	
6	Information Form for Ones and Toddlers (if applicable)	
7	Permission Forms	
8	Food Allergy & Special Diet Form	
9	Emergency Card (<i>State Form</i>)	
10	"Medication Administration form" (<i>State Form</i>)	
11	Signature Card: <i>Making the Difference for your Child (State Form)</i>	
COMPLETED BY CHILD'S PHYSICIAN/HEALTH CARE PROVIDER		
12	Health Inventory	
13	Health Inventory Addendum	
14	Immunization Record	
GIVEN BY CHILD CARE PROVIDER		
15	Entry code to the building	
16	Demonstration on the SIGN IN/OUT system	
17	Location of your child's classroom	
18	Location of payment drop off	

CENTER PARENT AGREEMENT

This agreement between _____, hereinafter “PROVIDER” who will provide child care services in Germantown, Maryland, and **Parents** _____ hereinafter “PARENT(S)”, who’s **child/children** _____ hereinafter “CHILD” will receive that care.

Both parties acknowledge that they have read and understand the *Parent Handbook* developed by PROVIDER and that both parties agree to abide by the provisions and terms of this document.

PROVIDER agrees that it will:

- A. Provide child care from: _____ (start time) to: _____ (finish time) for the weekdays of: []M []T []W []TH []F, except on the following holidays and professional days:
 - a. New Years Day (January 1)
 - b. Memorial Day
 - c. Labor Day
 - d. Fourth of July (July 4)
 - e. Thanksgiving Day
 - f. Day after Thanksgiving Center is open only from 8:30 a.m. – 4:30 p.m.
 - g. Christmas Day (December 25)
 - h. One (1) Professional Day (PROVIDER will provide parents with at least 2 months notice of actual date)
 - i. First day of both Eids
- B. Provide daily activities and learning materials that entertain, educate and develop the CHILD.
- C. Provide a safe and healthy environment for the CHILD.
- D. Provide PARENT(S) with lesson plans that are age-appropriate to the development of the child’s social, emotional and cognitive skills. PROVIDER will also distribute a monthly newsletter to PARENT(S) that will provide information on upcoming events and activities planned for the child’s classroom.
- E. Administer prescription and non-prescription medications to the CHILD in accordance with applicable state licensing guidelines. Please refer to the Medication Order Form for additional details.
- F. Exercise reasonable care and judgment in all matters relating to the welfare and safety of the CHILD.
- G. Take prompt and reasonable measures in the best interest of the CHILD in the event of accident or illness and promptly notify the PARENT(S) as soon as possible.

- H. Provide morning and afternoon snacks and a lunch supplement at no additional charge. Reserve the right to dismiss a CHILD if he/she acts in a disruptive manner or will not participate in regular and routine activities provided by PROVIDER.
- I. Not release the CHILD to any person other than the PARENT(S), legal guardian or person unless advance permission is given by the parent or legal guardian.

The PARENT(S) agree that they will:

- A. Drop-off and pick up their CHILD within the times set above or pay an overtime fee as agreed to below. The PARENT(S) will provide reasonable notice to PROVIDER if they will be late in picking up their child.
- B. Inform PROVIDER of illness, communicable disease, or problems with their CHILD that could affect other children in the care of PROVIDER and keep the CHILD home when presenting any of the signs of illness as outlined in the *Parent Handbook*.
- C. To pick up the CHILD immediately after being notified that the CHILD is sick. Sick care is not available. PARENT(S) are responsible for making other child care arrangements when the child is ill. Staff will observe children daily for symptoms of contagious illnesses before they are admitted for the day. If a child has a fever of 100.4 or higher, diarrhoea, vomiting and/or unexplained rash, or other communicable disease the child will be sent home. Children must be free of fever for 24 hours without medication before being readmitted to PROVIDER. A doctor's note is required to return children who are out for three or more consecutive days due to illness.
- D. Complete the Registration, All About My Child, Emergency Medical Information and Permission Forms.
- E. Insure that the child's immunizations are kept up to date, and provide the immunization information and physician's signature as required by state regulations. Failure to do so may result in your CHILD'S dismissal.
- F. Be liable for the CHILD'S illegal or destructive actions while at PROVIDER.
- G. Comply with all requirements and policies of PROVIDER.

The parties agree that in exchange for these child care services, the PARENT(S) will pay the PROVIDER the following fees:

- A. A non-refundable application fee of \$_____ for one child or \$_____ for a family.
- B. A \$_____ deposit, due upon signing and execution of this agreement, said deposit being equal to one week of the CHILD'S tuition. The deposit may be applied toward the CHILD'S last week at PROVIDER only after a two week written notice has been given in advance. In all other circumstances the deposit is forfeited.
- C. \$_____ weekly tuition payments, due each Monday by 6:30 p.m. whether the child is present or absent that day.

D. A \$_____ **late fee** for tuition received after 6:30 p.m. on Monday and a \$_____ **late fee** for tuition received after 6:30 p.m. on Tuesday.

E. **\$1 per minute** if the PARENT(S) fail to pick up the CHILD by the times stated above, due and payable upon arrival of the PARENT(S) responsible for picking up the child.

F. Activity Fee.

The parties agree that all such payments shall be made in cash, check, or money order, with a \$35.00 fee for returned checks. Parents who have a returned check may be placed on a 60-day probationary period during which time their check privileges are revoked and all payments must be made by cash or money order.

PARENT(S) agree that that a two-week written notice must be given to PROVIDER if the PARENT(S) decide to terminate this agreement. If notice is not given, PARENT(S) agree they forfeit their deposit.

This contract is legally binding on both parties and subject to enforcement through any lawful means. Any party in default is liable for attorney fees, court costs and any other expenses incurred in enforcement, if applicable..

Understood, agrees to and signed this _____ day of _____, 20____.

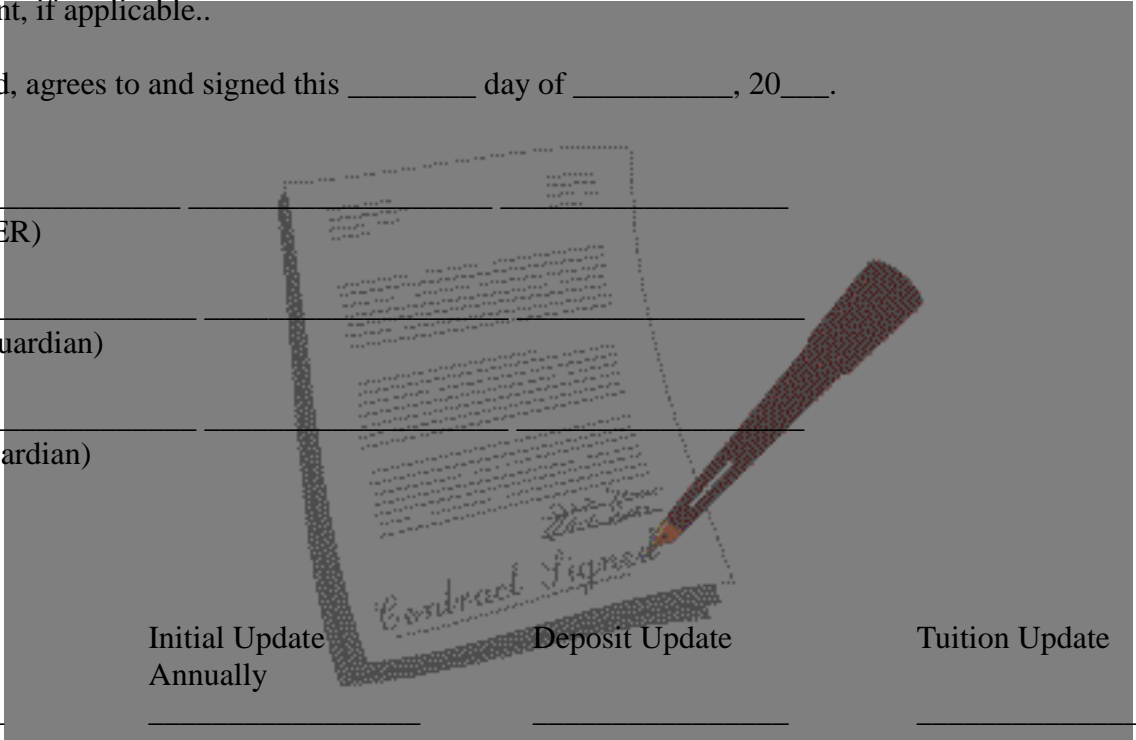
(PROVIDER)

(Mother/Guardian)

(Father/Guardian)

Updates:

	Initial Update Annually	Deposit Update	Tuition Update
20_____	_____	_____	_____
20_____	_____	_____	_____
20_____	_____	_____	_____
20_____	_____	_____	_____





GERMANTOWN KIDS ACADEMY AT ISG

ENROLLMENT FORM

CHILD'S INFORMATION

Child's Full Name: _____ **Birth Date:** ___ / ___ / ___
Address: _____ **Home Phone:** _____
City: _____ **State:** _____ **Zip Code:** _____
Nickname: _____ **Sex:** M F **Child Social Security#** _____
Circle Days Needed: Mon Tues Wed Thu Fri **Hours needed at Center:** _____ to _____
Circle one: Full Time Part Time Enrichment Program (9:30 a.m. – 3:00 p.m.)

PARENT/GUARDIAN INFORMATION

Mother's Full Name: _____ **Home Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Occupation: _____ **Work Phone:** _____ ext. _____
Name of Employer _____ **Cell Phone:** _____ **E-mail** _____
Business Address: _____ **City:** _____
Work Hours: _____ **Driver's License #** _____

Father's Full Name: _____ **Home Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Occupation: _____ **Work Phone:** _____ ext. _____
Name of Employer _____ **Cell Phone:** _____ **E-mail** _____
Business Address: _____ **City:** _____
Work Hours: _____ **Driver's License #** _____

Parent/Guardian with legal custody _____
 Parents are: Married ___ Living Together ___ Divorced ___ Separated ___ Widowed ___ Single ___

CHILD PICK-UP INFORMATION

Please list below the people who have ***Permission*** to pick up your child. ***Note: Anyone picking up your child must have picture ID.**

Name: _____ **Phone:** _____ **Pass Code:** _____
Name: _____ **Phone:** _____ **Pass Code:** _____
Name: _____ **Phone:** _____ **Pass Code:** _____
Child's Physician: _____ **Phone:** _____ **Emergency:** _____
Any allergies or special needs: _____ **Hospital preference:** _____

Information Sheet for Infants, Ones and Toddlers

1. What kind of milk or formula is your child taking now?

2. What are the appropriate times milk or formula is offered?

3. Is milk or formula offer by: Cup Bottle Breast

4. About how much milk or formula is offered at each feeding?

5. Does your child often get anything else to drink in the bottle? If yes, describe.

6. What foods other than milk or formula does your child get everyday?

IF NONE, CHECK HERE:

CHECK IN THE CHART BELOW THE KINDS OF FOODS AND TEXTURE:

Foods	Variety (List specific foods)	Texture		
		Baby Strained	Table	Junior
Cereals				
Fruits				
Juices				
Vegetables				
Meats				
Egg Yokes				
Eggs Whole				
Crackers/Toast/Bread				
Soups/Commercial Dinners				
Desserts				
Cookies				
Water				
Other				

7. How does your child usually take these foods?

Information Sheet for Infants, Ones and Toddlers

8. How does your child act when hungry?

9. Is feeding time a: Happy Time Frustrating Time Varies
Describe:

10. Are there any foods that do not seem to agree with your child?
YES NO If yes, what foods?

11. What happens if your child eats these foods?

12. How many teeth does your child have?

13. Does your child have any difficulty eating? (e.g., does he/she spit up frequently? Choke easily?) YES NO
If yes, describe:

14. How does your child act when sleepy?

15. At nap time is there anything special you do to promote sleep?

16. What is your child's nap time?

17. When cranky what seems to comfort your child?

Information Sheet for Infants, Ones and Toddlers

18. Is there anything special your child enjoys?

19. What is the normal bowel movement pattern of your child?

For Toddlers:

20. How are limits set?

21. Has toilet training started? YES NO

22. Comments:

Signature:

Parent/Guardian: _____

Date: _____

Permission Form

Child's Name: _____

To remain in child's record:

- I give permission to _____ to have my child participate in publicity or research activities in the child care program. I understand I will be notified of the location and time of such activities.
- I give _____ permission to take my child on supervised neighbourhood walking trips.
- _____ has taken every precaution to ensure that potential poisons are out of the reach of children. In the event that an accidental ingestion should occur, our staff will consult the Poison Control Center. In the event of an accidental ingestion, I understand that _____ staff will contact the Poison Control Center and will inform the parents immediately.
- I give my permission to _____ to take whatever emergency (e.g., first aid, disaster evacuation) measures that are judged necessary for the care and protection of my child while under the supervision of the PROVIDER.
- In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource (police, rescue squad) deems such transport necessary.
- It is understood that in some medical situations the staff will need to contact the local emergency resource before the parent, child's physician and/or other adult acting on the parent's behalf.
- I have received a copy of the PROVIDER policies and understand them.

Signature:

Parent/Guardian: _____

Date: _____

Food Allergy & Special Diet Form

Child's Name: _____

Please check one of the following:

- My child has allergies. *If you checked this box, please complete the form and sign below.*
- My child has no allergies that I am aware of. *If you checked this box, the form is not required, but any information that might be helpful to us would be appreciated.*

Please sign below regardless of whether or not you complete the form.

Foods that may not be served in any quantity	
Foods that may be served in small quantities	
Familiar foods that contain the basic food not to be served	
Is the child now being, or has the child ever been treated by a physician for an allergy? If so, when and for how long?	
What reactions does the child have when these foods are eaten?	
Additional Comments	

Signature: (Required)

Parent/Guardian: _____

Date: _____

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: _____	C: _____	H: _____
		W: _____		
		Place of Employment: _____	C: _____	H: _____
		W: _____		

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

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.
- **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://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

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
Last First Middle			Mo / Day / Yr		M <input type="checkbox"/> F <input type="checkbox"/>
Address: _____					
Number Street		Apt#	City	State	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W:	C:	H:	
		W:	C:	H:	
Where do you usually take your child for routine medical care? Name: _____					
Address: _____			Phone Number: _____		
When was the last time your child had a physical exam? Month: Year: _____					
Where do you usually take your child for dental care? Name: _____					
Address: _____			Phone Number: _____		
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"/>			
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"/>			
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 Poisoning/Exposure	<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"/>			
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?					
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____					
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____					
Does your child require any special procedures? (catheterization, G-Tube, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> 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:	Birth Date:	Sex
Last First Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

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: <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
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CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

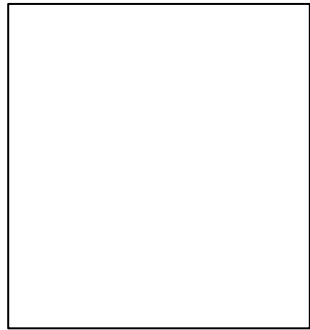
Allegany ALL	Baltimore (cont) 21220 21221	Cecil 21913	Garrett ALL	Montgomery 20783 20787	Prince George's (cont) 20782 20783	St. Mary's 20606 20626
Anne Arundel 20711 20714 20764 20779 21060 21061 21225 21226 21402	21222 21224 21227 21228 21229 21234 21236 21237 21239 21244 21250 21251 21282 21286	Charles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

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM**

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the facility.



Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects - Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature Date

Parental approval: _____
Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Health Care Plan Received: YES NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form Date

This Brochure Provides Information About:

- The requirements that State-regulated family child care homes and child care centers must meet,
- Your rights and responsibilities as the parent of a child in regulated care, and
- How and where to file a complaint if you believe your child care provider has violated State child care licensing regulations.

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education (MSDE), Division of Early Childhood Development. Within the Division, child care licensing is the specific responsibility of the Office of Child Care (OCC), Licensing Branch.

All child care facilities must meet minimum health, safety, and program standards set by Maryland law. To remain licensed, facilities must maintain compliance with those standards. Every licensed facility is inspected by OCC at least once each year to evaluate the facility's compliance with child care regulations.

OCC's thirteen Regional Offices are responsible for licensing activities, including:

- Issuing child care licenses;
- Inspecting child care facilities;
- Investigating complaints against licensed child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary to achieve compliance with regulations.

There are two types of regulated child care facilities: family child care homes and child care centers.

Family Child Care Homes and Child Care Centers Must Meet the Following Requirements:

- Have the approval of OCC, the fire department and other local agencies, as required (i.e., zoning, health, and environment).
- Provide care only in the areas of the facility that have been approved for use.
- Have the license issued by OCC posted where it is easily and clearly visible to parents. The license shows:
 - the maximum number of children who may be present at the same time;
 - the age groups which may be served; and
 - the facility's approved hours of operation.
- At all times, each child must be supervised in a manner appropriate to the child's age, activities, and individual needs.
- All areas of the facility used for child care must be clean, well lit, and properly ventilated. Room temperatures should be comfortable.
- If food service is provided, food must be stored, prepared, and served in a safe, sanitary and healthful manner.
- The facility must offer a daily program of indoor and outdoor activities that are appropriate to the age, needs and capabilities of each child.
- An up-to-date emergency information card must be on file and maintained for each child.
- The facility must post an approved emergency evacuation plan and conduct evacuation drills at least monthly.
- Child discipline procedures must be appropriate to a child's age and maturity level and may not include the deliberate infliction of physical or emotional pain. **Corporal punishment of any kind is strictly prohibited.**

ADDITIONAL INFORMATION

The Maryland Child Care Credential

Maryland has a voluntary child care credentialing program that recognizes child care providers' education, experience and professional activities at six levels.

Credentialed providers are authorized and encouraged to display the seal issued by the MSDE Office of Child Care.



Program Accreditation

Child care programs have the option of becoming state or nationally accredited. Accreditation means that the facility and staff have met program standards of quality.

Child Care and the Americans with Disabilities Act

The federal Americans with Disabilities Act (ADA) requires all child care programs to make reasonable efforts to accommodate children with disabilities. For more information about the ADA, please contact the OCC Regional Office in your area or one of the following organizations:

LOCATE: Child Care

Maryland Committee for Children, Inc.
608 Water Street
Baltimore, MD 21202
Phone: (410) 752-7588
www.mdchildcare.org

Maryland Developmental Disabilities Council

217 East Redwood Street, Suite 1300
Baltimore, MD 21202
Phone: (410) 767-3670
(800) 305-6441 (within Maryland)
www.md-council.org



State of Maryland
Martin O'Malley, Governor
Maryland State Department of Education
Nancy S. Grasmick
State Superintendent of Schools

OCC 1524 (rev. 12/2007)

A PARENT'S GUIDE

TO

REGULATED

CHILD CARE

* * *

*Important Information for
Parents of Children in
Child Care Facilities*

A publication of the
Maryland State Department of Education
Division of Early Childhood Development
Office of Child Care

www.marylandpublicschools.org/MSDE/divisions/child_care/child_care.htm

There are certain requirements that apply only to homes or centers.

Family Child Care Homes

- Up to 8 children may be in care at the same time if the home meets certain physical requirements. No more than 2 children under the age of two, including the caregiver's own, may be in care at the same time unless the home has been approved to serve additional children in this age group and an additional adult is present. Under no circumstance may care be provided at the same time to more than 4 children under the age of two.
- Each applicant for a family child care license must:
 - Have a criminal background check and child abuse/neglect clearance;
 - Submit a recent medical evaluation; and
 - Complete pre-service training requirements, including certification in first aid and CPR.
- Each adult resident of the home must also have a criminal background check and child abuse/neglect clearance.
- After becoming licensed, the caregiver must periodically complete additional training. Also, current certification in first aid and CPR must be maintained at all times.
- Each caregiver must have at least one substitute who is available to care for the children in the event of the caregiver's temporary absence from the home. Each substitute is subject to approval by OCC and must have a child abuse/neglect clearance. If paid by the caregiver, a substitute must also have a criminal background check. Before allowing a substitute to provide care, the caregiver must tell the substitute how to reach parents in the event of an emergency and familiarize the substitute with the home's child health and safety procedures.

Child Care Centers

The center director and staff members who have group supervision responsibilities must meet minimum education, experience, and training qualifications. They must also meet continued training requirements each year.

The director and all paid center employees must complete a criminal background check and a child abuse/neglect clearance, and submit a medical evaluation.

- In each classroom, staff/child ratios and maximum group size requirements must be maintained at all times. The following table shows some basic age groupings and the applicable requirements:

Age Group	Ratio	Maximum Size
0 – 18 months	1:3	6
18 – 24 months	1:3	9
2 years	1:6	12
3 – 4 years	1:10	20
5 years or older	1:15	30

- For every 20 children present, there must be at least one staff member who is currently certified in first aid and CPR.

Your Rights and Responsibilities as a Child Care Consumer

You have the right to:

- Expect that your child's care meets the standards set by Maryland's child care licensing regulations (NOTE: the regulations are available online at: www.marylandpublicschools.org/MSDE/divisions/child_care/regulat/);
- Visit the facility without prior notification any time your child is there;
- See the rooms and outside play area where care is provided during program hours;
- Be notified if someone in the family child care home smokes. In child care centers, smoking is prohibited;
- Receive advance notice when a substitute will be caring for your child in a family child care home for more than two hours at a time;
- Give written permission before a caregiver may take your child swimming, wading, or on field trips;
- Give written authorization before any medication may be administered to your child;
- Be notified immediately of any serious injury or accident. If your child has a non-serious injury or accident, you must be notified on the same day;
- File a complaint with OCC if you believe that the caregiver has violated child care regulations.

Any complaint you make to OCC about the care your child is receiving will be promptly investigated by OCC;

- Review the public portion of the licensing file for the facility where your child is or has been enrolled, or where you are considering enrolling your child.

How Do I File a Complaint?

If you wish to file a complaint, contact the OCC Regional Office in the area where the child care facility is located. Complaints may be filed anonymously. Listed below are Regional Offices and their main telephone numbers:

Region

1 – Anne Arundel County	410-514-7850
2 – Baltimore City	410-554-8300
3 – Baltimore County	410-583-6200
4 – Prince George's County	301-333-6940
5 – Montgomery County	240-314-1400
6 – Howard County	410-750-8770
7 – Western Maryland	
Hagerstown – Main Office	301-791-4585
Allegany Co. Field Office	301-777-2385
Garrett Co. Field Office	301-334-3426
8 – Upper Shore	410-819-5801
Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties	
9 – Lower Shore	410-713-3430
Somerset, Wicomico, and Worcester Counties	
10 – Southern Maryland	301-475-3770
Calvert, Charles and St. Mary's Counties	
11 – North Central	410-272-5358
Cecil and Harford Counties	
12 – Frederick County	301-696-9766
13 – Carroll County	410-751-5438

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated.

If you need additional help, you may contact the main office of the OCC Licensing Branch:

Program Manager, Licensing Branch
MSDE Office of Child Care
200 West Baltimore Street, 10th Floor
Baltimore, MD 21201
410-767-7805

Dear Parent/Guardian:

Maryland child care regulations require your child care provider to verify that you received a copy of "A Parent's Guide to Regulated Child Care." On the lines below, please write the name of each child you have placed in the care of this provider. **Complete and sign the statement at the bottom, tear off and give this portion of the brochure to the child care provider for retention in the facility's files.**

Child: _____

Child: _____

Child: _____

Child: _____

I, _____, have received a copy of the consumer education brochure entitled "Parent's Guide to Regulated Child Care."

Date

Signature of Parent/Guardian