



Little Learners Childcare Poolesville

919616 Fisher Ave, Suit A
Poolesville, MD 20837
(240) 489 3326

Application for Admission

Thank you for considering Little Learners Childcare Poolesville for your child's education and care. Please complete this form and return it to the center director along with \$100 your registration fee.

Student Name _____ Birthday _____

Sex _____ Enrollment Date _____ Potty Trained _____

Father's Information

Mother's Information

Full Name: _____

Home Address: _____

Phone Number: _____

Employer: _____

Work Number: _____

Email: _____

With whom does the child reside?

Father Mother both other (Please specify) _____

Responsible for Tuition _____

Parent Signature _____ Date: _____

****Little Learners does not discriminate based on race, color, or national origin in the admission of students and the employment of faculty and staff.**

OFFICE USE ONLY:

Enrollment Date: _____ Assigned Class _____ Tuition Rate _____



Handbook Signature Page

I/we agree to cooperate with the general policy of the Child Care facility, to perform the obligations of parents and guardians as set forth in the PARENT HANDBOOK, and to abide by the rules and regulations as set forth by Little Learners Childcare Poolesville.

My signature below indicates that I have read and understand all of the policies set forth in this handbook.

Parent/Guardian Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

Child's Name _____

Child's Name _____

Child's Name _____

**Maryland State Department of Education
Office of Child Care
Medication Administration Authorization Form**

Place Child's
Picture Here
(optional)

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.

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

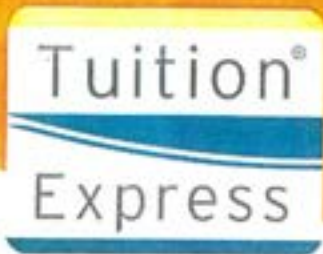
I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical 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 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
	2. Medication labeled as required by COMAR. <input type="checkbox"/> Yes <input type="checkbox"/> No	
	3. OCC 1214 Emergency Form updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	4. OCC 1215 Health Inventory updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No	

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express[®] – a payment processing system that allows 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
	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Routing Transit Number (see sample below)	Account Number (see sample below)

For Official Use Only

Date Received
Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of: Attach Voided Check Here \$ _____		
Deposit slips not accepted _____ Dollars		
⑆123456789⑆	18003308⑆	0226
Routing Number	Account Number	Check Number

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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: _____



Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) Information Sheet

Child's Name: _____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with LLCCP that way we can work together to ensure that the guidelines are put into practice. You are not obligated to provide this information if you do not wish to do so. Please indicate below if your child has an IEP/IFSP and if you wish to share it with LLCCP.

I am providing a copy of my child's IEP or IFSP

I am not providing a copy of my child's IEP or IFSP

My child does not have an IEP or IFSP

Signature: _____ Date: _____

Print Name: _____

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE _____/_____/_____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR
 GUARDIAN ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type													
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

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.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: Permanent condition OR Temporary condition until _____/_____/_____
 Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
 Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)



LITTLE LEARNERS CHILDCARE POOLESVILLE (LLCP)

919616 Fisher Ave, Suit A
Poolesville, MD 20837
(240) 489 3326

Photo/video Authorization Form

General Use

_____ I grant **LLCP** permission to photograph my child during observations, class projects, field trips, or any other classroom activity. I understand that only first names will be used and that the pictures may be used in any portfolio or displayed within the child care.

Website Use

_____ I grant **LLCP** permission to use my child's photo on their website, www.kkccclc.com I understand the website has a large audience and my child's photo will be available to the general public. (Photos only, No names will be used)

Facebook/Instagram/Twitter social media official pages

_____ I grant **LLCP** permission to use my child's photo on their Facebook/Instagram and twitter pages.

Child's Name _____

Parent's or Legal Guardian's Signature _____

Date _____

* This form is valid until written notice is given that LLCP no longer has permission to take/use child's photos.

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:
http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

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

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name:			Birth date:			Sex	
_____ 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: _____	
				W: _____		C: _____	
Your Child's Routine Medical Care Provider				Your Child's Routine Dental Care Provider		Last Time Child Seen for Physical Exam:	
Name: _____				Name: _____		Dental Care: _____	
Address: _____				Address: _____		Any Specialist: _____	
Phone # _____				Phone _____			
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.							
	Yes	No	Comments (required for any Yes answer)				
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>					
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>					
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>					
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>					
Bladder	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>					
Bowels	<input type="checkbox"/>	<input type="checkbox"/>					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>					
Coughing	<input type="checkbox"/>	<input type="checkbox"/>					
Communication	<input type="checkbox"/>	<input type="checkbox"/>					
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Feeding	<input type="checkbox"/>	<input type="checkbox"/>					
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>					
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>					
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>					
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>					
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>					
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>					
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>					
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>					
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?							
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)							
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmm_896_-_february_2014.pdf)

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.
Parent/Guardian Signature: _____ Date: _____

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

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

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1 Test#2	Test # 1 Test #2

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

Additional Comments: _____

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____
 STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: Male Female BIRTHDATE _____ / _____ / _____ PHONE _____

PARENT OR _____ / _____ / _____
 GUARDIAN LAST FIRST MIDDLE

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

Was this child born on or after January 1, 2015? YES NO
 Has this child ever lived in one of the areas listed on the back of this form? YES NO
 Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? YES NO

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

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

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

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

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

Comments:

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

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

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

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

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

Lead Risk Assessment Questionnaire Screening Questions:

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

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

For questions, concerns or to file a complaint contact your regional office

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worcester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

Resources

Child Care Subsidy - Assists parents with cost of childcare

[1-866-243-8796](tel:1-866-243-8796)

Consumer Product Safety Commission (CPSC) - regulates certain products used in childcare

cpsc.org

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org



Larry Hogan, Governor

Karen B. Salmon, Ph.D.

State Superintendent of Schools

Guide to Regulated Child Care



**Important
Information
About Child
Care Facilities**

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care’s (OCC), Licensing Branch.

The Licensing Branch’s thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary.

COMAR Regulations and other information about the Office of Child Care may be found at:

earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care



Child name: _____

Child name: _____

Child name: _____

Parent signature: _____ Date: _____

What are the types of Child Care Facilities?

Family Child Care – care in a provider’s home for up to eight (8) children

Large Family Child Care– care in a provider’s home for 9-12 children

Child Care Center – non-residential care

Letter of Compliance (LOC) – care in a child care center operated by a religious organization for children who attend their school

All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

Did You Know?

- Regulations that govern child care facilities may be found at: earlychildhood.marylandpublicschools.org/regulations
- The provider’s license or registration must be posted in a conspicuous place in the facility;
- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;
- Parents/guardians may visit the facility without prior notification any time their children are present;
- Written permission from parents/guardians is required for children to participate in any and all off property activities;
- All child care facilities must make reasonable accommodations for children with special needs;
- A “Teacher” qualified person must be assigned to each group of children in a child care center;
- Staff:child ratios must be maintained at all times in child care centers;
- Parents/guardian must be immediately notified if children are injured or have an accident in care;
- Child care facilities may have policies beyond regulatory requirements;
- OCC should be notified if a provider has violated child care regulations;
- Parents/guardians may review the public portion of a licensing file; and
- The provider’s compliance history may be reviewed on CheckCCMD.org.