Kids Kingdom Childcare and Learning Center

9900 Washington Blvd, Suite A,B and C
Laurel md 20723
(301) 776 7722

Application for Admission

Thank you for considering Kids Kingdom Childcare and Learning Center 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: _____

****Kids Kingdom 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 _____

KIDS KINGDOM
Child Care and Learning Center

FINANCIAL AGREEMENT
TUITION EXPRESS

On this __ day of _____ 20__, I, _____ have been fully advised of the services offered by Kids Kingdom Child Care and Learning Center (KKCCLC). I also understand that services are available from 6:30 a.m. to 6:30 p.m., Monday through Friday (excluding holidays and snow day). I do hearby enroll my son/daughter _____ into KKCCLC for their services. As compensation of these services I agree to pay:

- A one-time ONE week deposit of $ _____.00.
- A one-time NON-REFUNDABLE registration fee of $100.00, and
- An automatic ACH Payment of $_____.00 one week in advance of the care needed.

I understand that KKCCLC reserves the right to increase the weekly tuition at any time. Should this change occur a four week written notice will be given to the parent in advance. If my child's tuition is received after the close of business Monday, my account will be charged $10.00 for each day that the account remains past due.
I will receive no credit, discount or refund due to center holidays, snow days, acts of God, inclement weather, sick days or parent/child vacation time. I understand that the center closes at 6:30 p.m. and there is a late pick-up fee of $3.00 per minute. This fee will be credited to my account and will be pulled with the following ACH payment.
I understand that I will be required to pay my child's initial fees in the form of a money order, or certified bank check. All payments (i.e. tuition, late fees, pictures, field trips, etc.) will be deducted via my KKCCLC Tuition Express account. If an electronic payment is returned NSF, I understand that I will be charged a $35.00 return payment fee. Should there be an accidental draw on my account by KKCCLC, I will be reimbursed the amount of the accidental draw. Should my bank account be charged an overdraft fee due to this draw, then I shall be reimbursed a maximum of $35.00.
I understand that KKCCLC reserves the right to dismiss my child from the program for any valid reason with a two week written notice. Should I decide to withdraw my child from KKCCLC, I am required to give a two week written notification (with the week beginning on a Monday). I understand my one week deposit will be credited to my child's final week in the program. If no written notice is given, then I understand that I will be responsible for one week of service and will forfeit my one week deposit. NO refunds of deposit or tuition will be given.
It is my responsibility to cancel any third party payments in a timely fashion. Should there be any additional residual third party payments (i.e. NACCRRA, FEEA, etc) I will receive no refund.
Should my account incur a one week past due balance, I understand that services will be automatically suspended and that my one week deposit will be applied to my past due balance. Should there still be a remaining balance due and KKCCLC turns my account over to a collection agency, I agree to pay all back tuition and a 50% collection fee of the total.

_____ _____
Mother's Signature Father's Signature

_____ _____
Driver's License # Driver's License #

State: _____ State: ____

*Provider KKCCLC a copy of your driver's license.

_____
Notary Public

My Commission Expires: _____

Tuition® Express

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 cr Savings Account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required tc 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 _____

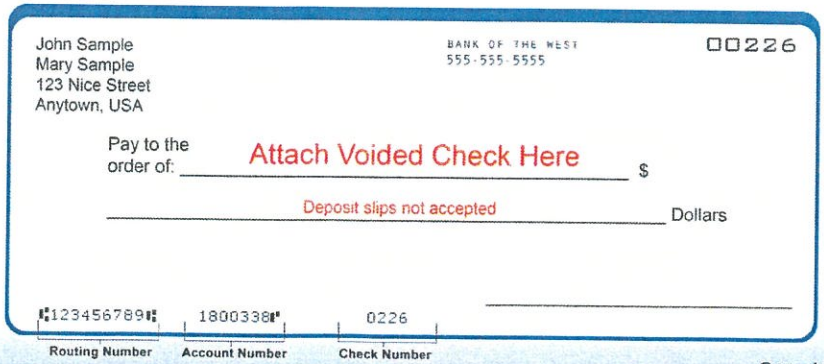
Bank or Credit Union Address _____ City _____ State _____ Zip _____

☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

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

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: _____

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 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** 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:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any Specialist :**

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

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

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

☐ No ☐ Yes, name(s) of medication(s):

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

☐ No ☐ Yes, type of treatment:

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

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

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

_____ _____
Signature of Parent/Guardian Date

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

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

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

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

REMARKS: (Please explain any abnormal findings.)

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

RELIGIOUS OBJECTION:

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

Parent/Guardian Signature: _____ Date: _____

5. Is the child on medication?

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

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ 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: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

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)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
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.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

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)

Maryland State Department of Education
Office of School and Community Nutrition Programs

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, age, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home

1. Child's Name	**Child's Date of Birth (MM/DD/YYYY)**

Times Child Normally in Care
(For example 7:30 AM – 5 PM)

Hours from:
_____ **to** _____

Check (✓) the days your child normally attends:

☐ Monday ☐ Thursday
☐ Tuesday ☐ Friday
☐ Wednesday ☐ Saturday
☐ Sunday

Check (✓) the meals that your child will receive while in care:

☐ Breakfast ☐ AM Snack
☐ Lunch ☐ PM Snack
☐ Supper ☐ Evening Snack

2. Child's Name	**Child's Date of Birth (MM/DD/YYYY)**

Times Child Normally in Care
(For example 7:30 AM – 5 PM)

Hours from:
_____ **to** _____

Check (✓) the days your child normally attends:

☐ Monday ☐ Thursday
☐ Tuesday ☐ Friday
☐ Wednesday ☐ Saturday
☐ Sunday

Check (✓) the meals that your child will receive while in care:

☐ Breakfast ☐ AM Snack
☐ Lunch ☐ PM Snack
☐ Supper ☐ Evening Snack

3. Child's Name	**Child's Date of Birth (MM/DD/YYYY)**

Times Child Normally in Care
(For example 7:30 AM – 5 PM)

Hours from:
_____ **to** _____

Check (✓) the days your child normally attends:

☐ Monday ☐ Thursday
☐ Tuesday ☐ Friday
☐ Wednesday ☐ Saturday
☐ Sunday

Check (✓) the meals that your child will receive while in care:

☐ Breakfast ☐ AM Snack
☐ Lunch ☐ PM Snack
☐ Supper ☐ Evening Snack

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____

Meal Benefit Application for Child Care Centers

July 1, 2021 - June 30, 2022

For more information, read **Instructions for Completing** or call **301-776-7722**

Step 1 — List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 — Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? Circle One: Yes No

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: ☐☐☐☐☐☐☐☐☐

Step 3 — Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: ☐☐☐☐

Check if No SSN: ☐

Step 4 — Contact Information and Adult Signature

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date: 07/01/21		Phone #:	

Step 5 — OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ _____

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: _____ Date: _____

Date Withdrawn: _____

KIDS KINGDOM
Child Care and Learning Center

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

Childs Name:_____

Your child's growth and development is is measured with developmental assessments. If your child currently has and IEP/IFSP, it would be beneficial to share a copy of this plan with KKCCLC 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 KKCCLC.

☐ 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 o IFSP

Signature:_____ Date:_____

Print Name:_____

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 & Worchester	**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

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

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Larry Hogan, Governor

Karen B. Salmon, Ph.D.
State Superintendent of Schools

OCC 1524 (10/2018)

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.

COVID-19 PUBLIC HEALTH EMERGENCY ACKNOWLEDGMENT AND DISCLOSURE FOR KIDS KINGDOM CHILD CARE AND LEARNING CENTER FAMILIES

This form should be reviewed and signed by all parents/guardians and emergency contacts.

Please read and initial each statement below.

1. ___I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the **KIDS KINGDOM CHILD CARE AND LEARNING CENTER** facility beyond the designated drop-off and pick-up area located. I understand that this procedure change is for the safety of all persons present in the facility, and to limit, to the extent possible, everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein and that they cannot pick up my child unless they also have signed this form.

2. ___I understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area I MUST wash/sanitize my hands before entering and wear a mask at all times. While in the facility, I must practice social distancing and remain at least six (6) ft away from all other people, except for my own child.

3. ___I understand that in order to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated away from the rest of the children and people located in the facility. I will be contacted by staff as soon as possible, and my child MUST be picked up from the facility within 30 minutes of being notified.

   Symptoms include: Cough, Shortness of Breath, Chills, Muscle aches, Headache, Sore Throat, Loss of taste or smell, Diarrhea, Fever of 100.0 degrees Fahrenheit or higher.

   Though many of these symptoms can also be related to non-COVID-19 issues, it is imperative that we proceed with an abundance of caution during this Public Health

Emergency. These symptoms typically appear 2-7 days after being infected, so please take them seriously.

4. ___I understand that Children, Parents, and Emergency Contacts, whom have been diagnosed with COVID-19, had symptoms of COVID-19, or otherwise have reason to believe they contracted COVID-19, and who want to return to KIDS KINGDOM before completing a 14-day self-isolation period, must present the Director with a medical professional's certification of good health that clears the individual for return. The medical certificate will be forwarded to HOWARD COUNTY HEALTH DEPARTMENT,

   who will consult with KIDS KINGDOM Management regarding whether the individual is able to return to the facility prior to completion of the 14-day period?

5. ___ I agree to wear a mask at all times while dropping off and picking up my child(ren) until notified otherwise by

6. ___ I understand that my child's temperature must be taken prior to their entering the facility, and after lunch/nap. I agree that on the mornings that I bring my child to KIDS KINGDOM, I will take my child's temperature with a personally owned temporal thermometer in the presence of a KIDS KINGDOM staff member and I will show the results to the KIDS KINGDOM staff member. I agree that my child will have their temperature taken by a staff member following lunch/nap and the results will be shared with me on sign in/ sign out sheet.

7. ___I understand that my child will be required to wash their hands using CDC recommended handwashing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.

8. ___I understand the importance of complying with state, county or local stay-at-home orders and social distancing orders, even when outside of care, in order to control my child's exposure in the local community.

9. ___I will immediately notify KIDS KINGDOM Management if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 3 above, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify KIDS KINGDOM management if I am made aware that anyone from my place of employment is presumed positive or tests positive for COVID-19, and I have been physically present in my place of employment within the last 14 days.

10. ___I understand and agree that if my child is diagnosed with COVID-19,

    KIDS KINGDOM must notify the State's Licensing Agent and the Maryland Department

of Health.

11. ___I understand that while present in the facility each day my child will be in contact with children, families, employees, and others with access to KIDS KINGDOM, who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

12. ____I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at KIDS KINGDOM ("Claims") arising from COVID-19 or related illness.

13. ____ On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless KIDS KINGDOM, their employees, agents, and representatives, of and from any Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out from COVID-19 or related illness.

14. ____ I understand and agree that this release includes any Claims based on the actions, omissions, or negligence KIDS KINGDOM, as well as their employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after attendance at KIDS KINGDOM.

I certify below that I have read, understand, and voluntarily agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by KIDS KINGDOM may result in termination of all KIDS KINGDOM services. I acknowledge that care for my child may be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Parent Name: _____

Signature:_____ **Date:** _____

Parent Name: _____

Signature:_____ **Date:** _____

Emergency Contact Name: _____

Signature:_____ **Date:** _____

Emergency Contact Name: _____

Signature:_____ **Date:** _____

KIDS KINGDOM CHILD CARE AND LEARNING CENTER

Center Owner/ Operator: **RAKHSHINDA SOHAIL**

Center Director: **KIMBERLY ALLEN**

Kids Kingdom COVID-19 FAQ's

1. What should I do if my child has COVID-19 symptoms?

   If your child has COVID-19 symptoms, your child should isolate at home until their symptoms improve and they have had no fever for at least 24 hours without medication.

2. If my child has symptoms and/or tests positive of COVID-19, when should I contact the school to inform them about my child?

   Please call/email Kids Kingdom Childcare, as soon as you notice COVID-19 symptoms and communicate it with us right away. This helps us follow-up on contact tracing as we continue to prioritize the health of the children and staff.

   You may contact the center using the following:

   Center Phone: (301) 776-7722
   Center email: kidskingdom.director@gmail.com
   Procare App

3. If my child has COVID-19 symptoms and no fever, can they still attend childcare?

   No, if your child has any symptoms of COVID-19 please make sure they are symptom free and return to childcare with a fitted mask.

4. When can my child return to childcare?

   According to CDC state and MSDE regulation, children are allowed to return to childcare if they are symptom and fever free after the 5-day quarantine. Upon return, children 2 years and up must wear a well-fitted mask upon return. Children under the age of 2 years must be fever and symptom free, complete the 10-day quarantine and return to childcare with a negative COVID-19 result.

5. If my child has had contact with someone who has tested positive, but has no symptoms, can my child attend childcare?

   If your child has no fever and is symptom free, your child can attend childcare.

6. Can my child attend childcare if someone at his/her household tests positive?

   If your child lives with someone who has tested positive, your child will not be allowed to attend childcare.

7. When can my child return to childcare, if someone in his/her household has tested positive?

   Your child can return to childcare if she/he is symptom free and if the person in your household is no longer having symptoms COVID-19. A negative COVID-19 test is required upon return.

8. When does my child need to wear a mask?

   According to CDC state guidelines and MSDE regulation, all children 2 years of age and above need to wear a fitted mask in a childcare setting. The only times children are allowed to take off their mask is during naptime, meal-time and outdoor play time (when social distancing is possible).

9. Will I be refunded for my child's tuition cost, incase my child is quarantined/ the classroom closes?
   If your child is quarantined/ isolated and cannot attend childcare, parent is responsible for the full tuition portion. However, if the health department has decided to close the center due to COVID-19 exposure, the center honor our parents with a 50% tuition discount.

Thank you for trusting us with the care of your little ones. If you have any questions or concerns regarding Kids Kingdom COVID-19 Policy, please do not hesitate to contact us at Kids Kingdom Childcare.

Dear parent/guardian,

Kids Kingdom is pleased to offer **My Procare**, a free online portal for you to access account information and easily pay tuition. My ProCare is safe, secure, and created with your convenience in mind.

Log in today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with Kids Kingdom) and choose ***Go***.

3. Enter the confirmation code sent to your email, choose a password, and press ***Go***.

4. Then you may:
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card. Please make sure you will be responsible for the processing fee, according to your card merchandise.

Thank you!

Kids Kingdom and MyProcare

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 Kids KingdomChild Care and Learning Center.

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 _____

KIDS KINGDOM CHILD CARE AND LEARNING CENTER

9900Washington blvd
Laurel MD 20723

Photo/video Authorization Form

General Use

_____I grant **KKCCLC** 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 **KKCCLC** permission to use my child's photo on their website, www.kkcclc.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 **KKCCLC** 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 KKCCLC no longer has permission to take/use child's photos.