Silver Spring Child Care Center
9525 Colesville Road
Silver Spring, MD 20901
Ph. 301-589-1593 Fax 301-589-0650
silverspringccc@aol.com
MSDE License # 118643

July 2018

Hello, new families! I am very excited to welcome you to the Silver Spring Child Care Center (SSCCC) community. This enrollment packet contains the following forms to be completed and submitted to SSCCC prior to your child's first day of attendance. The MSDE Office of Child Care requires that all forms be completed in their entirety. If an item is not applicable, write in "NA" in each data field.

1) **2018-2019 Enrollment Agreement**

2) **Emergency Form** – List at least two local contacts who can pick up your child in an emergency if we cannot reach you.

3) **Health Inventory** – Complete and sign Part I (page 2) and parts A, B,and D (if applicable) on Page 4. Your child's health care provider must complete and sign Part II (page 3). Page 3 may not be replaced by the physician with a computerized form or the School Age MSDE form.

4) **Immunization Record**

5) **Medication Administration Authorization –** Required before any medication or product, prescription or over-the-counter, may be administered by SSCCC

6) **Permission Form** – Permission for SSCCC to use your child's artwork, image, etc. for education and public information purposes and to share family contact Information with SSCCC families

7) **Child History** – Helps us get to know your child and plan engaging lessons and activities

Please feel free to call or send an email if you have any questions.

Thank you,

Cindy

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

Silver Spring Child Care Center

9525 Colesville Road, Silver Spring, MD 20901
(301) 589-1593

MSDE Office of Child Care License # 118643

Enrollment Agreement
July 1, 2018-June 30, 2019

Provision of Care

Care will be provided from 7:00 a.m. to 6:00 p.m., Monday through Friday except for professional development days and holidays (listed below) and unscheduled closings due to weather or other situations beyond the control of SSCCC. Monthly tuition includes breakfast, lunch and afternoon snack. Rest time is provided daily from 1:00 – 3:00 p.m. Children rest quietly on their cots for at least ½ hour. Children who do not sleep are offered quiet activities on their cots for the remainder of the rest time. Sleeping children will be allowed to sleep as long as needed and to awaken naturally as the noise and activity levels of the class increase.

Classroom Animals

As part of our curriculum, SSCCC welcomes various animals into our classrooms, including fresh water fish, turtles, tadpoles, frogs, caterpillars, butterflies, ants and other insects. All animals are maintained in healthy conditions and environments that children may view without coming into direct contact with the animals. We also invite a variety of animals to visit including petting zoo animals, bugs, reptiles, and pets from children's and staff members' homes. These animals are available for a part of a day, and interaction with the animals is under supervision of the animal owner and the teacher.

Discipline Policy

SSCCC believes discipline is helping children learn to live successfully within their community, to develop self-control, and to respect the rights of others. In order to foster this growth and development, children must know what is expected. They need routines, consistency and gentle reminders (along with good examples), as well as lots of positive reinforcement of acceptable behavior. Providing positive role models, establishing guidelines, and helping children learn to make good decisions on their own is the essence of our discipline policy. Any form of physical punishment or the denial of food, water, rest, or participation in activities is prohibited.

Because of the long-term benefits of participation in high-quality early childhood programs, our goal is not to suspend or expel a child from care. Instead, early childhood educators at SSCCC attempt to collaborate with families to bring the needed resources and strategies to each situation. Our goal is to resort to suspensions and/or expulsions only when there are extraordinary circumstances or a determination of a serious safety threat to self or others is made. While SSCCC will make efforts to reduce or eliminate such circumstances and/or threats with the provision of reasonable modifications, we reserve the right to suspend or expel in any situation we deem necessary.

Volunteers

All regularly scheduled volunteers undergo the same interview process, background check, medical clearance, and SSCCC orientation required for employees. Occasional volunteers, such as family members, do not undergo background or medical clearances. Teens 16 years and older may volunteer at SSCCC in order to fulfill their community service hours and are subject to the same rules and regulations as adult volunteers. Volunteers always work under the supervision of a staff member, and no volunteer is ever left alone with children. Volunteers are not provided with the access code to the building.

Withdrawal from SSCCC

SSCCC requires at least 30 days written notice of intent to withdraw a child from care. Tuition will be charged to the last day of care or 30 days from the date of written notice, whichever is later.

Tuition and Fees

Children enrolled in a two-year-old class or an older twos and younger threes class will be charged the two-year-old rate regardless of when they turn three. A child enrolled in one of the mixed-age classrooms will pay the two-year-old rate until the first day of the month after child is completely toilet trained.

We/I, ______________________________________ and ____________________________________, agree to pay the monthly fee of $1,389 for our/my child who is two, or older if not yet toilet trained, or $1,319 for our/my child who is three, four or five and fully toilet trained. We/ I understand that monthly payments are due on the 1st day of each month. We/I understand that bi-weekly payments can be arranged by speaking with the Director. Payments received after the 15th of the month should include a late fee of $25.00 unless other arrangements have been made. We/ I understand there is no reduction in fees for our/my child's absences and vacations, unscheduled closings, or for the following professional development days and holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day (Professional Development)
- Good Friday and Easter Monday
- Memorial Day
- Independence Day
- Professional Development Days: 3 days mid-August (August 17-21, 2018)
- Labor Day
- Thanksgiving Day & Friday
- Winter Break (December 26, 2018 through January 1, 2019)

Late Stay Fee

If an emergency arises, causing us/me to pick up a child after 6:00 p.m., we/ I agree to pay the late fee rate of $25 per child for each 10 minute increment or part thereof. We/I understand that the rate doubles after three late pick-ups in one quarter.

Returned Check Fee

We/I agree to pay a $25.00 fee when a check is returned by the bank for any reason. If a check is returned, SSCCC reserves the right to require payment by money order or certified check.

We/I understand, as stated in the Family Handbook, that if tuition payments fall behind two weeks or more, our/my child may be suspended from the program.

____
Child's Name

___________________________________ ______________________________________
Signature of Parent or Guardian Date

__________________________________ ______________________________________
Signature of Parent or Guardian Date

Representative, Silver Spring Child Care Center

___________________________________ ______________________________________
Cynthia H. Newsome, Director Date

Transitioning to Silver Spring Child Care Center

Welcome to SSCCC!

The following information will help you and your child make a smooth transition.

Preparatory Visit

We encourage you to schedule one or two visits with your child to his/her new class within a two-week period prior to his/her first day. We've noticed that the best time for these visits is between 9:30 and 11:00 while the children are busy with morning activities. This allows your child to enter into activities if he/she chooses to, and provides an opportunity for you and your child to talk briefly with the teachers in the classroom. Parents must remain in the building while their child is visiting.

If you feel that your child may need more visits before starting full time, please feel free to schedule additional visits. Children generally feel more comfortable in a new setting if their parent has spent some time with them there.

What to Bring

Every classroom has a special area for family pictures. **Please bring a picture,** or pictures, of as many members of your immediate family as possible, including pets!

Each child has his/her own cot, coat hook and cubby. SSCCC provides a clean cot sheet every week. We will provide you with a large, zippered bag for holding all naptime items; blanket, stuffed animal, etc.

Also bring:

- All completed forms from the New Student Packet
- A blanket for naptime and any soft sleep object (stuffed animal, blankie) your child may need in order to rest comfortably
- At least one extra change of clothing including shirt, pants, socks and underwear
- Diapers, wipes and diaper cream for children not yet potty trained
- Sunscreen labeled with your child's first and last name

If your child is potty-training you will need to bring:

- at least two extra sets of clothing and
- multiple pairs of underwear

Please feel free to call or email if you have any questions about making the transition. Our goal is to help make this time as easy and stress-free as possible for you and your child!

Looking forward,

Cindy Newsome
301-589-1593
silverspringccc@aol.com

Check the meal(s)that your child receives:
Breakfast ✓ Lunch ✓ Afternoon Snack ✓

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

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: ______________________ (Last / First / Middle) **Birth date:** __________ (Mo / Day / Yr) **Sex** M☐ F☐

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				
Lead Test 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 STATE DEPARTMENT OF EDUCATION
Office of Child Care

MEDICAL REPORT FOR CHILD CARE

A. Name of the Person Evaluated (Please Print): ______________________________ ______________________________ **B. Date of Birth:** ______________ **Age**: ______________ **C. Name and Address of Child Care Applicant/Provider/Facility:** ______________ ______________________________	**D. Reason for Examination:** ☐ Initial Employment ☐ Biennial (Two Year Update) ☐ Other

E. This person to be evaluated either provides/plans to provide child care services or lives in a home where child care is provided or will be provided. The Medical Evaluation is to assess this individual's ability to perform the following Child Care Activities

- Lifting, carrying children (infants, young children)
- Lifting/moving children furniture/equipment
- Getting up and down from floor
- Close interaction with children
- Food preparation, serving, feeding and holding young infants
- Desk work, reading & writing
- Active indoor and outdoor activities
- Facility maintenance
- Driver of Vehicle (s)
- Others: please list

F. This Section Must Be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner

	Yes	No	Remarks
1.Did you conduct a medical evaluation?			
a. Chronic medical conditions(Diabetes, Heart Disease, Hypertension, Epilepsy , Asthma, others)			
b. Impairment (Mobility/ Vision/ Hearing/ Speech)			
c. Nervous / Emotional/ Mental health disorder			
d. Drug /Alcohol Abuse			
e. Smoking			
f. Tuberculosis Screening: (1) symptoms check (2) screening: if needed or required by the Local Health Officer: Type of test: ________________Results: __________________ Date (s): ____			
g. Communicable/Contagious diseases risk			
h. Immunization status			
2. Medical condition(s) or medication (s) the person is taking that may restrict /prevent the person's ability to perform care activities			
3. Medical limitation(s) or medication(s) the person is taking, that may require special accommodation: Please specify			
4. Based on your findings, is this individual suitable to provide safe care to the children in child care or to live in a child care home.			

Additional Remarks:

G. Signature of the Health Care Provider: **Date:**

Printed Name & Credentials:

STAMP OR Complete Address of the Health Care Provider & Telephone Number:

Allergy Action Plan

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: ______________________ Date of Birth: __________

ALLERGY TO: ______________________

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	 Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.

***IMPORTANT:** Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

Doctor's Signature ______________________ Date __________

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: ______________________ Phone Number: __________

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	 Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration

I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

Parent/Guardian's Signature ______________________ Date __________

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: ______________________ **Date of Birth**: ____________

ALLERGY TO: ______________________

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐

EPIPEN® (Epinephrine) Auto-Injectors 0.3/0.15mg

userguide

blue safety release cap

orange tip

1 **Pull off the blue safety release cap.**

HOLD for 10 seconds

2 **Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.**

Please note: As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine, which you inject into your outer thigh. DO NOT INJECT INTRAVENOUSLY. DO NOT INJECT INTO YOUR BUTTOCK, as this may not be effective for a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.

Call 911

3 **Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.**

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

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EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Dey Pharma, L.P.

The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Triggers (list)

____
____
____
____
____
____
____

Student's Name:______________________________ DOB:______________ PEAK FLOW PERSONAL BEST:________________

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

	Medication	Dose	Route	Frequency
☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: ______________ ☐ Peak flow greater than _______ (80% personal best)				
☐ Prior to exercise/sports/ physical education	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Quick Relief Medications — to be <u>added</u> to Green zone medications for symptoms

	Medication	Dose	Route	Frequency
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: ______________				
☐ Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in ______ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

RED ZONE: Emergency Medications— Take these medications and <u>call 911</u>

	Medication	Dose	Route	Frequency
☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs				
☐ Lips or fingernails blue ☐ Trouble walking or talking				
☐ Other:______________ ☐ Peak flow less than _________ (50% personal best)	Contact the parent/guardian after calling 911.			

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children) ☐Yes ☐No

Prescriber signature: ______________________ Date: ________ Parent / Guardian Signature: ______________________ Date: __________

Reviewed by Child Care Provider: Name: ______________________ Signature: ______________________ Date: __________

3/20/2014

Silver Spring Child Care Center

Child Information

Your child's cared is a shared responsibility. To meet your child's needs SSCCC teachers would like to have a better understanding of their developmental history and family culture. All information is confidential and made available only to your child's primary caregiver. Please help us by completing this form in detail and use the last page to elaborate on any questions.

Family Information

Name of Child_______________________________________ Date of Birth________________________

Date Completed_____________________________________ Current Age of child___________________

Ethnicity/Race of the child (please circle all that apply):

- Hispanic/Latino
- American Indian or Alaska Native
- Asian
- Black or African American

Native Hawaiian or other Pacific Islander
White
Other

Parent/Guardian #1____

Parent/Guardian #2____

Custody/Visitation Arrangements____
(all legally enforced court orders must be submitted with the child's record)

Sibling Names and Ages _____________________________ ______________________________________

_____________________________ ______________________________________

Other Household Member and relationship____

What Languages are Spoken at Home? ____

Are there special words we need to use to communicate with your child?

Developmental & Health History

How would you rate your child's overall health? ____

Does your child have a chronic illness or medical conditions which would impact their participation in our program? No Yes describe____

Does your child have any physical disability or limitation? No Yes________________________________
Does your child run high fevers easily? ____
Does your child have Allergies? ____
(if Yes Allergy action plan but be on file)

Does your child have Asthmas? ____
(if Yes Asthmas action plan but be on file)

Do you have concerns about your child's speech? ____________________________________

Do you have any other concern about your child's physical growth or development?
____

Do any of these special needs require special care by our teachers? ___________________________

What programs or individuals work with your child in regards to their special needs?
____
(Please sign a release of information so they can inform us about how to provide enhanced support to your child)

Sleep Habits
Does your child nap? _____________________________________
The child normally sleeps at night from_______________ to________________________
Upon awakening the child mood generally____
Does your child have their own room? ____
A special item to sleep with? ____

Eating Habits
What are your child's favorite food? ____
What food does your child dislike or refuse? ____
How would you rate your child's eating habits? ____
Does your child eat with their hands or utensils? ____
Does your child have eating difficulties? ____

Toilet Habits
Is your child fully toilet trained? No yes
What word does your child use for urination? ____
Can your child indicate toileting needs? No yes
Does your child have frequent toileting accidents? No Yes
Fear of toilet? No yes
The child wears… diapers Pull-ups or training pants underwear

Social Relationships

Describe your child's relationship to others? ____
____

Describe some activities your child enjoys home____
____

Describe some activities your child enjoys at home ____
____

Would you describe your child as Friendly Shy Aggressive Withdrawn Other?
____

What makes your child happy ____
What would make your child upset or angry____
How does your child show their feelings ____
Has your child had experiences playing with other children ______________________________
What age group does your child prefer to play with ___________________________________
Does your child know other children at the center ____________________________________
How do you feel your child will adjust to the program _________________________________
Does your child have difficulty with separation _______________________________________
Does your child relate well to other adults?____
How does your child interact with other children and adults _____________________________
____

What do you think will happen the first day you leave your child with us __________________
____

Describe any fears your child may have ____

Personal History

Briefly describe your child personality, abilities and interest ____________________________
____
____
____

Tell us about your child's favorite toy and game____
____

What discipline approach is use at home ____
____

What expectations or goals do you have for your child at the center, or list aspects of ways we can support your child and family ____
____

In social relationships____
____

In emotional development ____
____

In physical Development ____
____

In cognitive and intellectual growth____
____

Your Child in Care

Has your child been in an early leaning or child care before ______________________________________

What type of care? How long? ____

Is there any information about your family, culture, ethnicity or religion that is important for us to know? ____

____

____

Are you willing to volunteer in our program____

Would you and /or your family like to be a resource for cultural awareness activities? _______________

Do you have any questions about the family handbook?____

What times are best for you to come in for parent conferences or to reach you?____________________

____

Do you have any questions about the program, curriculum or facility? ____________________________

____

Additional Information

____

____

____

____

____

____

____

____

____

Check the meal(s)that your child receives:
Breakfast ✓ Lunch ✓ Afternoon Snack ✓

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

Family Permissions

Likeness and Images

SSCCC may wish to display children's faces, performances and/ or art work on our website and printed materials which are used to advertise the Center. Children's first names may be included (on a piece of artwork, for instance) but last names will not. Please indicate your consent below.

___ I hereby grant permission to SSCCC to publish my child's artwork, performance, likeness and/or voice on social media sites and printed publications for the purposes of education, instruction or public information without the use of my child's full name.

___ Do not use my child's artwork, performance, likeness and/or voice for any purpose without first contacting me for specific permission.

___ I do not consent to the use of my child's artwork, performance, likeness and/or voice for any purpose except in-house displays.

Contact Information

SSCCC promotes a sense of community among its members, both within and without the Center. In order to support families arranging play dates and social events or coordinating volunteer activities in the classrooms, SSCCC publishes a Center-wide Family Directory for use within the SSCCC community only. Families are prohibited from using or selling the information in the Family Directory for any other personal or business use.

____ I authorize SSCCC to include the following contact information in the Family Directory. (Circle your selections)

Family names   Cell Phone Numbers   Email Addresses   Physical Addresses

____ I do not wish my contact information shared with other families.

I am of legal age and competent to execute these statements, which I have read and fully understand. By signing this form I agree to use family contact information only as authorized by SSCCC.

___________________________________   _________________________________

Child's Name (Print)   Date

___________________________________   _________________________________

Parent/Guardian Name (Print)   Parent/Guardian Signature

___________________________________   _________________________________

Parent/Guardian Name (Print)   Parent/Guardian Signature

Food Substitution Form

Child's Name:		
Reason:		
***Parents may be required to provide substitutions.		
Food Substitution List		
Milk/Dairy	*****Allowed Substitutes**	**Texture (e.g., cut up, ground mince, puree, liquidity)**
Meat & Meat Alternative	*****Allowed Substitutes**	**Texture (e.g., cut up, ground mince, puree, liquidity)**
Bread, Cereal or Whole Grain Products	*****Allowed Substitutes**	**Texture (e.g., cut up, ground mince, puree, liquidity)**
Fruit & Vegetables or Juice	*****Allowed Substitutes**	**Texture (e.g., cut up, ground mince, puree, liquidity)**
Additional Dietary Concerns and/or Required Equipment or Assistance Needed:		
I (parental authority) certify that the above child requires special accommodations/diet as indicated above.		
Print Name	Parent Signature	Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 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
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
______	______	______	______
______	______	______	______
______			

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

1. ____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)
2. ____
Signature Title Date
3. ____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _______/_______/_______
Date

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

Signed: ____ Date ____________________
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: ____ Date: ____________________

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 DHMH 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 DHMH COMAR 10.06.04.03 are available at www.dhmh.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.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

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.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

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 &special Instructions: ____________________

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

Known Food or Drug: Allergies? Yes No If Yes, please explain ____________________

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 attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

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 Heath Care Plan Received: ☐ YES ☐ NO

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

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE