# Easter Seals Child Development Center
# Private Pay Intake Packet

These forms MUST be returned before a child can start in the center

- ❑ Maryland State Department of Education Health Forms
  - -Health Inventory
  - -Immunization Record/schedule
  - -Blood Lead Screening
- ❑ Maryland State Department of Education Emergency Form
- ❑ Maryland State Department of Education All About My Child
- ❑ Maryland State Department of Education Guide to Regulated Care
- ❑ Easter Seals Childcare Application
- ❑ Placement Agreement/Therapy Services
- ❑ Easter Seals Meet My Child Form
- ❑ Illness Policy
- ❑ Parent Permission Form
- ❑ Parent Handbook Acknowledgement
- ❑ Resting Consent Form
- ❑ Lunch Refrigeration Waiver
- ❑ Acknowledgement of Notice Regarding Nut Allergies
- ❑ HIPPA (Privacy Notice Consent Form)
- ❑ Intake Packet Receipt/Completion Acknowledgement
- ❑ Parent Financial Information Fact Sheet
- ❑ Tuition Express Form

- ❑ Easter Seals Center Closings (retain for reference)
- ❑ Easter Seals CDC Handbook (retain for reference)
- ❑ Easter Seals Inclement Weather Policy (retain for reference)

## Acknowledgment of Intake Packet Receipt/Completion

I, _____, with my signature below, acknowledge that I have received all of the
Parent Name (Please Print)

documents outlined above, which are meant to inform me about my rights and responsibilities.

X_____ _____
Parent Signature Date

## Completion of Intake

_____ X_____
Date Packet Completed Director Signature

Parent Financial Information Fact Sheet

# INTERGENERATIONAL CHILD DEVELOPMENT CENTER
# MONTHLY TUITION RATES

## Effective 1 September 2015

| Classroom | Monthly Rate |
|---|---|
| Poliwogs, Bumble Bee 1 | $1907 |
| Frogs, Tadpoles, Bumble Bee 2 | $1907 |
| Caterpillars, Butterflies | $1638 |
| Ladybugs | $1,491 |
| Grasshoppers | $1,491 |

**NOTE:**

- Tuition is paid in advance of services, on the first of each month
- Rates can change with a 30 day notice.
- Tuition is reflective of staff- child ratios assigned in classrooms.
  NOTE: Tuitions do not change on a child's birthday.
- If the center closes for facility, weather related problems, parents are responsible for the full tuition.

**ADDITIONAL FEES:**

| | |
|---|---|
| Waiting List Fee | $100 for one child<br>$25.00 each additional child |
| Initial Registration Fee per child | $100.00 |
| Tuition Deposit | 50% of Tuition<br>Applies to Last Month's Tuition<br><br>Families receiving a subsidy are subject to 25% deposit |
| Annual Re-Registration per child | $100 |
| Late Tuition Payment | $25, to be applied after the 5th buisness day on non payment |
| Late Pick- Up Fee | $15 per 15 minute interval per child |
| Returned Check/declined credit card | $50 |
| Field Trip | Per individual field trip |
| Hot Lunch provided by Good Foods | $80 per month<br>NOTE: After child is 12 months |
| Spanish Classes | $180 per 10 week session |

| | |
|---|---|
| **Power Tots** | **$40 per 4 sessions/month;<br>$10 reg. fee** |
| **Drop – In Rate** | **$100 per day** |

**NOTE:**

- **Tuition Rates are subject to change annually**
- **Families will be given a thirty day notice for tuition increase**
- **All tuition is paid through Tuition Express via your credit card or electronic checking account withdrawal. We accept Visa, MasterCard, American Express, or Discover credit cards.**
- **If you prefer to pay by personal check, there will be an additional $15.00 added to the tuition rate/fee.**

**Notice of Withdrawal**

Parents must notify the Center in writing 30 business days before the child's last day. Tuition for the full month is charged for children who exit prior to the last day of the month when less than 30 business days notice is provided. This includes children who are graduating from the center.

**Non-Refundable Initial and Annual Registration Fee:**

Due annually September 1: **$100.00** per family

For new enrollees registering in June, July and August, the **$100.00** registration fee is waived until the September 2016.

**NOTE: Both Initial and Annual registration fees are non-applicable to tuition.**

**Holiday Policy and Professional Development Days:**

Your tuition for child care services are computed on an annual basis and broken down into 12 monthly payments. Therefore, all holiday and center closings are taken into consideration when determining your fees and cannot be deducted off your tuition when they occur. The center will be closed for all federal holidays and four (4) professional development days. Fees will not be reduced due to these closings.

Child's Name and Room Assignment_____

**I have read and understand the Parent Financial Information Fact Sheet.**

_____ _____

**Signature of Parent/Guardian** **Date**

_____ _____

**Signature of Parent/Guardian** **Date**

**Please keep a copy and return a signed copy to the center**.


# Parent Handbook Agreement

I have received the Easter Seals Parent Handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures of the Easter Seals Parent Handbook and to abide by them. In addition, I understand that this handbook reflects organization-wide policies and that supplemental center and state specific policies may apply.

I understand that it is my responsibility to go directly to center administrators with any questions I may have regarding the policies, procedures, and information contained in the Easter Seals Parent Handbook for further clarification

Information contained in this guide may be subject to change based on revisions of licensing regulations, NAEYC standards and criteria and Easter Seals' policies and procedures. Parents will receive center-wide communication as this occurs.

_____

**Parent/Guardian Signature**

_____

**Date**

_____

**Parent/Guardian Signature**

_____

**Date**

**NOTE:**
This is a copy of the agreement you have signed and returned with your initial enrollment materials or annually at the time of revisions for the Parent Handbook. The signed copy is located in your child's file at the center.

# 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

## 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

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://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.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://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

## EXEMPTIONS

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

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

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

## INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/36556/1216_MedAuth_073013.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: |

**Where do you usually take your child for routine medical care? Name:**

**Address:** **Phone Number:**

**When was the last time your child had a physical exam? Month: Year:**

**Where do you usually take your child for dental care? Name:**

**Address:** **Phone Number:**

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

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

**Does your child take medication (prescription or non-prescription) at any time?**

☐ No ☐ Yes, name(s) of medication(s):

**Does your child receive any special treatments?** (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

**Does your child require any special procedures?** (catheterization, G-Tube, 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://marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/docs/DHMH_896_revFeb2011.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

**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: ☐Yes ☐No | | |

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

Additional Comments:

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

## CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age.

**If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.**

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

### AT RISK AREAS BY ZIP CODE

**Allegany**
ALL

**Anne Arundel**
20711
20714
20764
20779
21060
21061
21225
21226
21402

**Baltimore**
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219

**Baltimore (cont)**
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
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21718
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21758
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21769
21776
21778
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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
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20838
20842
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20877
20901
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20913

**Prince George's**
20703
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20743
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20752
20770
20781

**Prince George's (cont)**
20782
20783
20784
20785
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20788
20790
20791
20792
20799
20912
20913

**Queen Anne's**
21607
21617
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21644
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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

# 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 | Dose # | Hep A Mo/Day/Yr | MMR Mo/Day/Yr | Varicella Mo/Day/Yr | History of Varicella Disease |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 | | | | Mo/Yr |
| 2 | | | | | | | | | 2 | | | | |
| 3 | | | | | | | | | | Td Mo/Day/Yr | Tdap Mo/Day/Yr | FLU 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 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)

Intergenerational Center
EASTER SEALS CHILD DEVELOPMENT CENTER
1420 Spring Street Silver Spring MD 20910

# Acknowledgement of Notice Regarding Nut Allergies

I,_____, parent of _____,
Name of Parent (please print) Name and Age of Child (please print)

understand that, due to the seriousness and frequency of nut allergies, IGC Easter Seals Child Development Center has requested that I not send in any item containing products that are made with nuts/nut oils/nut products, or have been processed on machines or in factories that process nuts or nut products. I also understand that this request applies to both foods that I send in for my child's personal consumption, and to foods that are to be shared with other children.

I understand that ALL foods brought in for celebrations or other activities within the classroom must be commercially prepared and packaged with an ingredients label clearly visible. This applies to cut fruits and vegetables as well.

I understand that if my child consumes any foods containing nuts or traces of nuts prior to coming to the Center, I will thoroughly clean my child's hands and face prior to my arrival.

I also understand that IGC Easter Seals Child Development Center itself does not provide food containing nuts or nut products, and that:

- children's allergy information will be clearly posted by staff;
- all parents will be informed and reminded about food allergies;
- teachers will remind children that food sharing is prohibited, as I am myself as a parent encouraged to remind my own child;
- children will be asked to wash their hands upon arrival at the Center, before and after school mealtimes; and that
- staff are trained in recognizing signs of anaphylaxis, emergency protocols, and the use of epinephrine pens.

I further understand that, despite their best efforts, IGC Easter Seals Child Development Center cannot ensure that every family will read every label or that a child will come to school without nut products on their face and hands.

Signature of Parent_____Date_____

Signature of Teacher_____Date_____

**FORM L**

INTERGENERATIONAL CENTER
EASTER SEALS CHILD DEVELOPMENT CENTER
1420 Spring Street, Silver Spring MD 20910

# COT RESTING CONSENT FORM

I, _____, parent of_____
Name of Parent (please print) Name & Age of Child (please print)

give permission for my child to sleep on a cot once he/she turns 1 year old. I hereby give my permission and consent for the above named child to sleep on the cots provided by the Center. I also understand that it is my responsibility to provide sheets for the cot and that I will be responsible for taking home my child's cot sheets to wash on a weekly basis and that I will return clean ones to be used by my child the following week.

Signature of Parent_____Date_____

Signature of Teacher_____Date_____

# 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?**<br>(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 DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE**

CHILD'S NAME_____/_____/_____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____/_____/_____/_____
ADDRESS CITY STATE ZIP

SEX: ☐ MALE ☐ FEMALE BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT _____/_____/_____/_____
OR LAST FIRST MIDDLE PHONE
GUARDIAN _____/_____/_____/_____
ADDRESS CITY STATE ZIP

## CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003**,** the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

## RECORD OF BLOOD LEAD TESTING

**Test #1**. _____ **Test # 2.** _____ Comments: _____
Date Date

Signature _____/_____
Health Care Provider or Designee OR School Health Professional or Designee Date

## RECORD OF BLOOD LEAD TESTING EXEMPTION

I, _____ certify that my child does not **AND** has never resided in an at-risk area.
Parent or Guardian (Print)

Signature_____ / _____
Parent or Guardian Date

**COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.**

## RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed _____ / _____
Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed_____/_____
Health Care Provider Date

## HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) 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. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

## Maryland Childhood Lead Poisoning Targeting Plan
## At Risk Areas by Zip Code

**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
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21234
21236
21237

**Baltimore Co. (Cont.)**
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

**Frederick . (Cont)**
21757
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21776
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21791
21798

**Garrett**
ALL

**Harford**
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21034
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21082
21085
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21111
21160
21161

**Howard**
20763

**Kent**
21610
21620
21645
21650
21651
21661
21667

**Montgomery**
20783
20787

**Montgomery (Cont)**
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

**Prince George's**
20703
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20913

**Queen Anne's**
21607
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21644
21649
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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

Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate http://www.fha.state.md.us/och/html/lead.html