Before & After School Enrichment

Dear Y Families,

Thank you for enrolling your child in the largest provider of licensed quality Before & After School Enrichment (BASE) in MaMaryland. At the Y in Central Maryland, we've designed our programs to include all the things parents feel are most important -- ample amounts of love, attention, fun, games, homework help, healthy snacks and engaging activities in clean, safe environments where kids have lots of choices, can make new friends and discover what they love!

We're excited to offer **for the 2015-2016 school year, our NEW complimentary Y Family Membership *included* with all full-time enrollments!** This is a great opportunity to engage in healthy family fun at all 12 Family Center Y's! Please see the enclosed flyer for more information about this exciting new full-time participant benefit!

To finalize your registration, all families must complete the attached forms and return them via fax or email no later than August 14, 2015 for the start of the school year. *Children's files must be complete for program attendance.* **Parents should submit completed paperwork to the Y Customer Billing office via fax at 410-779-9426 or email to billing@ymaryland.org.**

□ Registration Agreement
□ EFT Form (must be renewed annually)
□ Enrollment & Liability Release/ Medication Information Form
□ Emergency Care Plan
□ Emergency Contact Form
□ Medication Administration Authorization Form
□ Asthma Action Plan (if applicable)
□ Allergy Action Plan (if applicable)
□ Health Inventory Part I & Part II
□ Immunization Certification
□ Parent's Guide to Regulated Child Care

Tuition payments are due monthly starting August 1st ending May 1st. The Y offers several payment options including credit card EFT, online payments, walk-in to centers, over-the phone credit card payment, and check by mail.

Please look for additional information on School's Out Days and other programs, and the Parent Handbook at your child's site. Should you have any additional questions, please feel free to contact Customer Billing at 443-322-8000 option #1 or visit us on the web at www.ymaryland.org.

Thank you again. We look forward to a great school year!

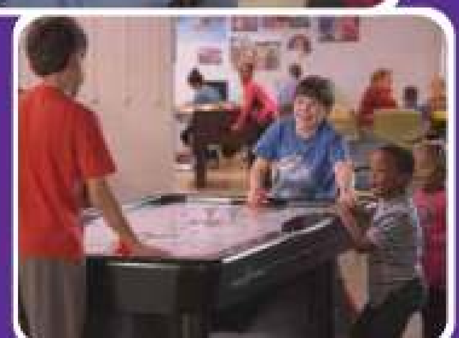
Sincerely,

Derryck D. Fletcher

Vice President of Youth Development

NEW FOR 2015/2016 Y BEFORE & AFTER SCHOOL ENRICHMENT

All Full-time Participants Receive a Complimentary Y Family Membership *Included* with Enrollment!



Get Ready to Go to Your Happy Place!

- **Complimentary family membership good at all 12 Family Center Ys for the 2015/2016 school year (valued at over $800)!**
- Enjoy full Y member benefits including free exercise classes like Zumba, yoga, cycle and others; free activities like Funshops for kids, rockwall climbing, lap swim, family swim and more; free monthly events like movie nights and BBQs; all under one roof at the Y!
- Save on Y programs like swim lessons, youth sports and martial arts!
- Complimentary family membership valid Sept. 1, 2015 through Jun. 15, 2016. Extend your membership over the summer months with our Summer Bridge Membership and save on Y Camp too!

How to Get Started

- Register full-time for the 2015/2016 Y Before & After School Enrichment program.
- Bring your approved registration form to any Family Center Y to redeem your complimentary family membership.

For more information on activating your complimentary family membership, the summer bridge membership for the 2016 camp season, or any other questions, please contact your Site Director or the Y Customer Billing office at 443-322-8000 or billing@ymaryland.org. **SEE YOU AT THE Y!**

Before & After School Enrichment

Y of Central Maryland

It's deeper here.

Find a Y near you at ymaryland.org

The Y in Central Maryland • It's deeper here®

Before & After School Enrichment – School Year 2015-2016 PROGRAM REGISTRATION FORM: Anne Arundel County

Child's Name ______ DOB ______ Grade (entering Fall 2015) ______ Gender ______

Home Address ______ City ______ State ______ Zip ______

***Primary Parent /Guardian Name** ______ Cell Phone ______ Work phone ______

Address (if different from child's) ______

Parent/Guardian Name ______ Cell Phone ______ Work phone ______

Address (if different from child's) ______

***Primary email address**: ______ **Primary phone number**: ______

*Please note that Primary Parent list above will receive all emails, tax information, and family membership details.

Race (optional): ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hispanic/Latino ☐Native Hawaiian/Other Pacific Islander ☐Two or more races ☐White/Caucasian ☐Other

Household Income (optional): ☐$0-$19,999 ☐$20,000-$39,999 ☐$40,000-$74,999 ☐$75,000-$99,999 ☐$100,000+

How did you hear about the Y? ☐School ☐Family Center Y ☐Friend ☐Email ☐Web Other ______

Hours of Operation: All Sites Before School Enrichment open at 7:00 a.m. After School Enrichment ends at 6:00 p.m.

School Sites (please select): ☐ Glen Burnie Park ☐ Jessup ☐ Millersville ☐ Richard Henry Lee ☐Rippling Woods ☐ Rolling Knolls ☐ Shipley's Choice ☐Southgate

Start date requested: ______ *(Child's start date is subject to change based on acceptance of payment/required paperwork)*

Enrichment needed (please Select)**:** ☐Full Time (5 days) ☐Part Time (3 days) Mon☐ Tues☐ Wed☐ Thurs☐ Fri☐

Registration Fee: $60.00 *(Registration fee is non-refundable and non-transferrable. Fee is due at time of registration.)*

Monthly Rates: (please select)

	Before & After School Enrichment		After School Enrichment Only		Before School Enrichment Only	
Full Time:	☐	**$373**	☐	**$259**	☐	**$170**
Part Time:	☐	**$303**	☐	**$214**	☐	**$152**

A 10% sibling discount is also available, subject to restrictions. First payment is due August 1 and last payment is due by May 1. A $25.00 late fee is assessed after the 5th of each month. All cancellations and changes to enrichment must be submitted in writing two weeks before the requested cancellation/change date along with a brief explanation and parent/guardian signature to the Customer Billing Office.
Financial Assistance: Available on a sliding scale to those who would otherwise be unable to participate. DSS vouchers are also accepted.
Schools Out Day Programming: When schools are out for teacher meetings, holidays, or inclement weather, and based on site availability, we will attempt to provide a full day of theme activities which may have additional fees. Space is limited. A fee will be assessed for those that register for School's Out Days, but do not attend as scheduled. Contact Customer Billing for details on School's Out Days costs. **Professional In-Service days and Snow days are included in Full Time Before & After School Enrichment participant's tuition payment.**

Emergency and Medical Information: I acknowledge that I must have my child's completed emergency and medical forms on file prior to my child's first day. If forms aren't current and on file, I understand that my child will not be permitted to start care.
Registration Payment: (please select)
☐I would like my EFT account ran for registration fee payment. (2015-2016 EFT form is attached in packet)
☐After August 1st, please run EFT for 1st months tuition payment.
☐I will call into Customer Billing (443-322-8000) at my earliest convenience to make payment.

I have read and understand the Y's payment schedule and policy (**Initial**) ______.
I understand my child is not fully registered for enrichment programming until I make payment on the account and receive a confirmation email from Billing. **(Initial)** ______

My signature, or electronic signature, below gives permission to enroll my child in the Y's Before and After School Enrichment program.

Parent/Guardian printed name ______ Date ______

Membership Registration Form
Before & After School Enrichment

Start Date: September 1st 2015-End Date: June 15th 2016

Please select type: ☐**Full Time Before & After,** ☐ **Full Time After Only** ☐ **Full Time Before Only.**

PRIMARY PARENT MEMBERSHIP INFORMATION

Name of Primary Parent* ______ **Gender** ______ **DOB** ______

Email Address ______ **Phone Number** ______

***Please make sure the primary Adult on the membership is the primary parent listed on the Before & After School Registration form. The primary parent receives all Before & After School Enrichment information, billing receipts, tax information, and membership notification and information.**

ADDITONAL ADULT MEMBER INFORMATION

(Family Membership can have up to 4 adults residing in the same Household)

FULL NAME ______ **Gender** ______ **DOB** ______

FULL NAME ______ **Gender** ______ **DOB** ______

FULL NAME ______ **Gender** ______ **DOB** ______

DEPENDENT INFORMATION

Full Name ______ **Gender** ______ **DOB** ______

Full Name ______ **Gender** ______ **DOB** ______

Full Name ______ **Gender** ______ **DOB** ______

Full Name ______ **Gender** ______ **DOB** ______

Instructions for activating your Y Family Membership: Please bring a copy of this form and your Before & After School Enrichment registration form to your select primary family center to activate your membership. Please note Before & After School Families will be asked to have a photo taken and receive their access cards prior to using the family centers.

PRIMARY Y FAMILY CENTER LOCATION FOR MEMBERSHIP

(Please select one primary Family Center)

☐**Catonsville Family Center**
☐**Druid Hill Family Center**
☐**Harry & Jeanette Weinberg Family Center**(Baltimore City)
☐**Parkville Family Center**
☐**Orokawa Family Center**(Towson)
☐**Y Swim Center at Dundalk**
☐**Dancel Family Center** (Ellicott City)
☐**Greater Annapolis Family Center** (Arnold)
☐**Hill Family Center**(Westminster)
☐**Perry Hall Family Center**
☐**Walter & Betty WardFamily Center**(Abingdon)
☐ **Y Swim Center at Randallstown**

Policy Notes: Please note, if you cancel your Y Before & After School Enrichment full-time enrollment, your complimentary membership will be cancelled and the standard monthly family membership rate will be applied to your account.

WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT: In consideration for use of the YMCA facilities and participation in YMCA programs, I understand that the Y in Central Maryland assumes no responsibility for injuries or illnesses which I (or my dependents) may sustain as a result of my physical condition or resulting from participation in any athletic activities, sports program, the use of any equipment, exercises or other activities. I expressly acknowledge on behalf of myself and my heirs that I assume the risk for any and all injuries and illnesses which may result from participation in these activities. I hereby release and discharge the Y in Central Maryland, its agents, assigns and/or employees from any and all claims for injury, illness, death, loss or damage which may result from my participation in these activities. I understand that the Y in Central Maryland is not responsible for personal property lost or stolen while members and/or program participants are using Y facilities or on Y premises.

I HAVE READ AND AGREE TO THE ABOVE WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT

Signature of Primary Member/Parent Guardian (if under 18) ______ Date ______

The Y in Central Maryland • It's deeper here®

Before & After School Enrichment
School Year 2015-2016

Please review the information listed below to ensure that you understand your responsibilities and agreements in enrolling your child in the Y Before and After School Enrichment Program.

Demographic Information

The Y receives financial grants, gifts, and donations from public and private sources. Many of these sources require us to provide an overview of the customers and communities we serve such as age, grade, sex, and number of children by school or community, as well as race and household income. Specific and individual information about you or your family is never isolated and shared. This information is helpful, but optional. Please see the BASE Program Registration Form for details.

Tuition

Tuition is billed monthly and in advance of services received. Tuition is calculated by taking the yearly program fees that cover the days that school is in session and dividing that into 10 equal monthly payments beginning August 1, 2014 or at time of registration and ending May 1, 2015. Tuition prices are subject to change. ________(Initial)

Monthly Tuition Payments

Payment is due on the 1st of each month. A $25.00 late fee is applied after the 5th of the month for any account with an outstanding balance. If payment is not received by the 8th of the month, then the child will be unable to attend the program until the balance is paid in full. Payments not received by the 15th of the month will result in termination. We may then contact our waitlist for openings. Re-enrollment, should there be space, will require the balance to be paid in full and a new registration fee to be paid in full. Note: late fees are assessed based on date payment is received by customer billing office, not by postmark date. A payment schedule has been provided for your reference. ________(Initial)

Payment Options

All payments must be received by mailing a check to the Customer Billing Office, or credit payment over the phone or online. Site and/or center directors are not allowed to collect monthly payments. The Y in Central Maryland accepts money order, American Express, Discover, MasterCard & Visa credit cards, and Electronic Fund Transfers (EFT). The Y will also gladly accept your personal check; however, there will be a $25 charge for any check returned to us unpaid by your bank________(Initial)

Financial Assistance

The Y in Central Maryland accepts DSS and other third party payment arrangements that may be able to assist you. We also have a Financial Scholarship program to assist families in need. Applications are available through the Customer Billing Office. ________(Initial)

Changes in Program Enrollment

All enrollment changes must be made in written form and sent to the Customer Billing Office, two (2) weeks prior to the change. Site/center directors cannot accept verbal notification of changes or withdrawals. Parents are responsible for contractual payments. There is a $10 processing fee for refunds and changes in care. Registration fees are neither refundable nor transferable. Snow days, School's out Day and have separate cancellation and credit/refund policies. ______(Initial)

Absentee and Sick Child

There will be no reduction of fees if a child is absent from the program, including illness. The Health Department's regulations concerning periods of infection will be enforced.______(Initial)

Closings and Early Dismissals

There will be no reduction of fees for holiday closings, emergency closings, or if the site is forced to close due to circumstances beyond the Y's control (i.e. water main break, power outage, severe/inclement weather, etc). For sites located within the school system . . . the Y is unable to run programming on **emergency** early dismissal days. Programs or half-days, and extra days of programming may require advance registration and may have additional fees and separate credit/refund policies. ______(Initial)

In-Service Days/School's Out Day

A variety of options will be made available for days when school has planned time off. A schedule of activities, registration procedures, and fees will be made available prior to these days. Please note that these days are beyond the planned school days as covered by the before and after enrichment tuition and some additional fees may apply. Payment and registration forms are due within 5 days of the date of service. Late payment fees and suspensions for non-payment may apply. ______(Initial)

Custody Issues

If there are any custody issues, the parent will provide a court order indicating who is the custodial parent/guardian and the names of anyone in which the staff should NOT release the child. It should be noted that there is one account for each family. If the account is outstanding, regardless of whose responsibility it is to make payment, then care may be suspended or terminated. We require parents to communicate with each other and that they refrain from placing our staff in the middle of any custody issues. Failure to do so could result in immediate termination. ______(Initial)

Sign-In and Sign-Out

Children must be accompanied into and out of the program space by a parent or an authorized adult (at least 18 years of age) at all times. An authorized adult must sign the in/out roster and present photo ID to ensure that this safety regulation is enforced. ______(Initial)

Late Pick-up

The BASE program closes promptly at 6:00pm (school sites) and 6:30pm (preschool locations). Parents are considered late if the child has not been picked up by the times listed above (regardless of the reason). Any parent arriving late will be charged a late fee of $5 per child for every five minute increment or fraction thereof. There is no cut-off time for this fee and the authorities will be notified for any children remaining past 7:00pm. Repeated lateness could cause dismissal from the program. Payment is due within 24 hours of date of late pick-up – late payment fees and suspensions for non-payment may apply. ______(Initial)

Forms and Account Information

It is the parent/guardian's responsibility to notify the staff of any medical information pertinent to their child's health, safety and well-being; and to provide updated medical records as necessary. It is also the responsibility of the parent/guardian to keep telephone and emergency information updated on their child's emergency card and on account with the site director and the customer billing office. ______ (Initial)

Medical and Emergency Incidents

If a medical emergency arises, the Y staff will first attempt to contact the parent/guardian. If the parent/guardian cannot be reached, staff will try to contact emergency contacts until someone is reached. If the emergency is such that immediate hospital attention is necessary, the staff will accompany the child to the hospital in an ambulance. ______ (Initial)

Illnesses/Health Conditions

Children may not attend the program if they have any illness or condition that compromises the health of other children or staff. Health Department regulations regarding periods of infection will be enforced. Children must be symptom-free (vomiting, fever, and diarrhea) for at least 24 hours before returning to the program. Additionally, a doctor's release will be required in order for any child to return to the center after a communicable illness. ______ (Initial)

Damaged Property

If a child accidentally or deliberately breaks or damages Y in Central Maryland property or the property at the site location, the parent/guardian will be held responsible for the replacement cost of the equipment. ______ (Initial)

Behavioral Issues and Suspension

If a child is having problems adjusting to the program, a conference will be arranged between staff and parent/guardian. Serious behavioral problems may result in a suspension period with no reduction in tuition. A child may be dismissed from the program without notice if his/her behavior is consistently disruptive or if his/her behavior threatens the health and safety of himself or the safety of other children or staff. Additionally, if a parent/guardian displays such behavior or acts within a manner that is inappropriate, his/her child may be dismissed from the program.______ (Initial)

Permissions/Other

- I give my permission for my child to participate in walks and other activities within the grounds of the site.______(initial)
- I give the Y in Central Maryland permission to request a copy of my child's IEP enrollment/intake documentation and, if applicable, schedule of special education services (if applicable) ______(initial)

Special Considerations: Please check off any of the following that you as a parent feel our Y staff should take into consideration in order to provide the best experience for your child: ______Special nutritional or dietary needs ______Lower staff to student ratio (current ratio 1:15)

- Other considerations or comments:____

My signature indicates I have read and understand the Before and After School Enrichment Program Agreement. I agree to read the Parent Handbook in its entirety and to comply with all policies and procedures stated within. I understand failure to adhere to these policies may result in termination from the program. I certify that my child is fully able to participate in this program. In case of voluntary withdrawal, or if my child is removed from care, I understand there will be no refund of tuition fees for the period covered.

Child's name:_____________________ Parent's name________________________: Date: _____________

I also give permission, without compensation in any form, to the Y in Central Maryland to use without limitation or obligation, photographs, video footage, or tape recordings, which may include my child's image and/or voice for purposes of promoting and/or interpreting Y programs.

Parent/Guardian's signature:_________________________

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Y in Central Maryland
EFT Activity Authorization Form
School Year 2015-2016

Member #:_______________

(Office Use Only)

Service Location: ___________________________

☐**Before & After School Enrichment/ (Monthly, 1st day of month from Begin Date to 5/1/16)**

Account information:

Child's Name:_____________________________ Phone (Cell): ______________________________________

Cardholder's Name:_________________________ Phone (Work): ____________________________________

Street Address:_____________________________ City ______________ State ______ Zip ______________

Email Receipts to: ____

Payment Information: Billing Method (select one): ☐VISA ☐ MASTERCARD ☐AMEX ☐DISCOVER

Account Number: ___________________________ Expiration (Month/Year):________________

Security Code (back of card): _______________

Before & After School/Chips – 1st Date to run card: 35T

Monthly Amount: $____________

Credit Card Electronic Fund Transfer Authorization and Agreement

To THE Y IN CENTRAL MARYLAND (herein referred to as the Y): I have given my authority to charge the above named credit/debit card for the activity payments indicated above. It is understood that the Y's transmission of the EFT to the card issuer as payment becomes due and shall constitute valid notice of such payment due on the above named activity. When the above named EFT is processed, such charge shall constitute my receipt for the payment. Should any EFT not be honored by the card issuer, it is understood that payment is to be made by me within three (3) days for the amount of said payment, plus a service fee of $25. I understand that this authorization will remain in effect only until the dates noted above. If I choose to terminate the EFT authorization prior to paying my tuition in full, I understand I must initiate its termination by giving the Y 30 days written notice in advance of the date I wish the EFT to stop. Failure to give 30 days written termination notice will result in that month's charge being non-refundable even in the event I am withdrawing my child from the Preschool/Before and After School Enrichment program. I further understand that all credit/debit card information changes must be given to the Y with 30 days written notice in advance of the date I want the change to occur.

I understand that after two unpaid charges, the Y may immediately terminate this agreement and Program enrollment until I have brought all payments up to date.

I acknowledge the terms of the transfer authorization and agreement as stated above:

Customer Name: ________________

Customer Signature: ________________ **Date:** ________

Registration & Payment Instruction Page

Registration Payment Instructions:

- At time of registration parents will need to pay the full registration fee to secure a spot. The $60 registration fee is non-refundable and non-transferrable.
- We request that registration fees be made either over the phone with our Customer Billing Department or with an Electron Funds Transfer (EFT) on file for initial registration.
- Families with current outstanding balances will not be able to register until their outstanding balance is paid.
- First payment for the first four weeks of enrichment programming is due on Aug 1st. Students who enrolled in the program after the official start date of the program will be prorated to reflect their start date.
- An additional prorated tuition payment may also be due depending on your start date; please contact Customer Billing with questions.
- Once payment is received Customer Billing will send a confirmation email confirming your completed registration, child's name, start date, and program type.

Monthly Online Payment Instructions:

1. Go to the following link: http://ymaryland.org/billinginquiries. Select 'make payment'. Select 'program type' in the drop down box; type in child's first and last name; and type in child's program location. Then, select the 'Pay Now' button.
   - Type in the amount in the order summary and click "Update".
   - If you have a Paypal account, enter your Paypal login information and click "Pay Now to complete transaction using your debit, credit card, or checking account.
   - If you do not have a Paypal account, click "Don't have a Paypal account" and complete the required fields, including email address, phone number, and debit/credit card.

Please note: You do **NOT** have to have a PayPal account to make a payment online. There are 3 ways to pay:

2. From a computer, use your existing Paypal account:

   - Click "Send Money"
   - Type in the "To" field: billing@ymaryland.org
   - Type in the amount and select "I'm paying for goods and services"
   - Select "no shipping required"
   - In the "Message (optional)" box, **enter the child(ren)'s name and program location to ensure your account is credited correctly and timely**.

3. From a mobile device, use your existing Paypal account:

   - Click "Send"
   - Type in the "To" field: billing@ymaryland.org
   - Type in the amount
   - In the Message box, **enter the child(ren)'s name and program location to ensure your account is credited correctly and timely**
   - Under "What's this payment for?", select the button for goods or services
   - Click "Review", then "Send

Important note! Payments will be credited to your account the same day, but will not be reflected in our system until the following business day. A receipt will be sent to the primary email address on file; **please make sure this is current**. Also please note, **the online payment system cannot be used to secure your space in a Y program, only to pay an existing balance due**.

We encourage you to take advantage of the online payment option. However, should you need to speak with anyone from the Customer Billing department, please do not hesitate to call us at 443-322-8000. As always, billing questions, forms, and scanned documents can all be directed to our team by emailing billing@ymaryland.org.

Before & After School Enrichment Payment Due Dates

2015-2016 School Year

If child starts during School Week beginning:	And ending:	Billing Start Date:	Number of Installments/ EFT:
Start of School Year	September 25, 2015	August 1, 2015	10
September 28, 2015	October 23, 2015	September 1, 2015	9
October 26, 2015	November 20, 2015	October 1, 2015	8
November 23, 2015	December 18, 2015	November 1, 2015	7
December 21, 2015	January 22, 2016	December 1, 2015	6
January 25, 2016	February 19, 2016	January 1, 2016	5
February 22, 2016	March 18, 2016	February 1, 2016	4
March 21, 2016	April 22, 2016	March 1, 2016	3
April 25, 2016	May 20, 2016	April 1, 2016	2
May 23, 2016	End of school year	May 1, 2016	1

Before & After School Enrichment   School Year 2015-2016

ENROLLMENT & LIABILITY RELEASE/ MEDICAL INFORMATION

Required for child to participate in program

I am a legally competent adult who is parent or guardian of the named participant. I would like my child to participate in Y in Central Maryland programming and expressly give my permission. I understand that even when every reasonable precaution is taken, incidents and accidents may occur. Therefore, in exchange for the Y in Central Maryland allowing my child to participate, I voluntarily and intentionally hold harmless and release the Y, its directors, officers, employees and agents from all liability for loss, damage, injury, or death, including any claims based on ordinary negligence, action, or inaction connected in any way with such participation, except for any loss, liability, damage or cost that is caused solely by the Y's gross negligence. I also agree to indemnify the Y in Central Maryland for claims made by or for the participant or claims arising from any relationship with the participant or the participant's estate.

I have read this form and grant permission for my child, ____, to participate in all activities provided by the Y in Central Maryland.

Parent's signature____ ***Date***_______________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, ____, should become ill or injured during Y activities, I understand that the Y will: 1) contact me immediately; 2) contact the person(s) I have designated in case I cannot be reached.

Should the Y be unable to reach me or the person(s) designated, the Y is authorized to contact my physician or arrange for immediate medical treatment to ensure the health and safety of my child, including the administration of medications or injections provided by me for such purpose.

I accept responsibility for payment of medical services rendered.

Parent's signature____ ***Date***_______________________

MEDICAL ALERT INFORMATION (list any allergies, medical and/or handicapping conditions)

___

___

___

Physician name____ Telephone_________________________

Physician address____

Emergency Contact____ Telephone______________________

Emergency Contact ____ Telephone________________________

The Y in Central Maryland • It's deeper here®

Before & After School Enrichment School Year 2015-2016

EMERGENCY CARE PLAN

My child ______________________ please check one: ☐ **does** / ☐ **does not have an allergy.**
Child's name

Sign form at bottom either way. Complete all information for allergies even if medication is not necessary.

Grade:__________ Age:____ Date of Birth:_______ Site ________________________________

Parent/Guardian Name:____ Cell phone: _______________

Work ________________ phone:_______________ Home phone:______________________________

Address:____

To provide assistance to this student experiencing an allergic reaction:

Type of allergy: __________________________
____

Identify triggers which start an allergic reaction: _________________________________
____
____

Possible allergic signs: ___________________
____
____

OTHER CONSIDERATIONS: _______________
____

____

____

____

ACTIONS TO TAKE (Do This)

Stay calm.
Stay with the child.
Ask someone to contact 911 and/or parent
Are medications at the Y program? Yes/No
Medications on file to treat child:

____

____

In order for the Y to administer medication, a completed Medication Administration Authorization Form must be on file.

Other care options:
____
____
____
____
____
____

CALL 911 if student has:

- **Difficulty breathing or noisy breathing**
- **Tightness of chest**
- **Swelling of tongue, eyes, or lips**
- **Swelling/tightness in throat**
- **Difficulty talking and/or hoarse voice**
- **A wheeze or persistent cough**
- **Loss of consciousness and/or collapse**
- **Vomiting, stomach cramps, or diarrhea**
- **Blue discoloration of lips or fingernails**
- **Becomes pale and floppy**

Administer CPR if breathing stops! Continue until paramedics arrive!

I give consent for the Y in Central Maryland authorities to take appropriate action for the safety and welfare of my child. I give my consent for the Y in Central Maryland authorities to communicate with the authorized health care provider when necessary.

Parent Signature:____ **Date:** _____________________

Place Child's Picture Here

Allergy Action Plan

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

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 0.3/0.15 mg

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 added 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 call 911

	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

EMERGENCY FORM

INSTRUCTIONS TO PARENTS/GUARDIANS:
(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.

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 __________

— —

Child's Name ______________________ Birth Date __________
Last First

Enrollment Date __________ Hours & Days of Expected Attendance __________

Child's Home Address ______________________
Street/Apt# City State Zip Code

Mother/Guardian's Name ______________________ Home Telephone __________
Last First

Employer/School ______________________
Name Address

Home Address (*If different from above*) ______________________
Street/Apt# City State Zip Code

Work Telephone __________ Cellular Phone __________ Beeper __________

Father/Guardian's Name ______________________ Home Telephone __________
Last First

Employer/School ______________________
Name Address

Home Address *(If different from above)* ______________________
Street/Apt# City State Zip Code

Work Telephone __________ Cellular Phone __________ Beeper __________

Name of Person Authorized to Pick-up Child *(daily)* ______________________
Last First Relationship to Child

Address ______________________
Street/Apt# City State Zip Code

ANNUAL UPDATES __________ __________ __________ __________
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html *Select DHMH 896.*
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* *http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: ______________________ **Birth date:** __________ **Sex**

Last First Middle Mo / Day / Yr M☐F☐

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:			Birth Date:	Sex
Last	First	Middle	Month / Day / Year	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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

RELIGIOUS OBJECTION:

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

Parent/Guardian Signature: Date:

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

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

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

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

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.

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.**
- **An adult must bring the medication to the facility.**

Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: ______________________________ Date of Birth: ______________

Condition for which medication is being administered: ______________________________

Medication Name: ______________________ Dose: ______________ Route: ______________

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

If PRN, for what symptoms: ______________________________

Possible side effects - Specify: ______________________________

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

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

Telephone: ______________ FAX: ______________

Address: ______________________________

____

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

This space may used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

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

Parent/Guardian Signature: ______________________________ Date: ______________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

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

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

Prescriber's authorization: ______________________________
Signature — Date

Parental approval: ______________________________
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from: ______________________________ Date: ______________

Special 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

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