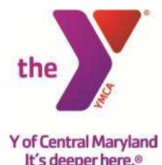


Preschool Welcome Letter

2015-2016 School Year

Welcome to the Y of Central Maryland. We are delighted that you have chosen to enroll your child in our program. **Our curriculum-based program is rated parent's number one choice in preschool programs.** Here are some helpful hints that should get your child off to a great start:

1. The following information must be completed and submitted to the Director **prior** to your child's first day:

   - Registration Form w/Registration Fee
   - Emergency Card
   - Enrollment/Liability Release
   - Allergy Emergency Care Plan
   - Swim Permission Slip *(if applicable)*
   - USDA Paperwork *(if applicable)*
   - Payment for Two Weeks of Care
   - Registration Agreement
   - Financial Issues Statement
   - Immunization Record
   - New Health Inventory Form w/Lead Addendum
   - IEP or IFSP *(if applicable)*

2. Please contact the billing department at 443-322-8000 to ensure that you understand our tuition requirements and other financial issues **prior** to your child's first day.

3. Tuition payments are due every Friday. Payments can be made online, over the phone, via EFT (electronic funds transfer), check, or money order and should be made out to the Y. **A late charge of $25 will be applied to any account not paid in full by the due date.**

4. On your child's first day, please bring the following items labeled with your child's name:

   - Quiet time bedding *(crib-sized sheet, travel-size pillow, small blanket – stored in a pillow case)*
   - Diapers and wipes *(if child is not yet potty trained)*
   - Sweater-sized plastic box/lid or Ziploc bag with a complete change of clothing inside
   - A nutritious packed lunch *(with nothing to heat up please)* if applicable
   - Swim suit, towel, and sandals packed in a canvas bag for swim or water play days
   - Composition book
   - 2 Family photos

5. Your child will be assigned a cubby and a mailbox. When you drop off your child, please sign them in, put their belongings in their cubby, and escort them to their classroom. When you pick your child up, please sign them out, collect their items from their cubby, and check their mailbox for information/projects to be sent home.

6. In each classroom you will find a parent board with information on our snack menu, curriculum, lesson plans, and daily routines.

7. Please do not bring toys from home into the center. We provide plenty of activities for your child to enjoy.

Thanks again for enrolling your child in our program. Please contact us if you have any questions or concerns.

UMBC

2015-2016 Student Registration Form

Office Use Only:	
Start Date:____________	Class:____________
Amt Owed:____________	Amt Paid:_________
☐ Teacher Notified	Initials__________

Student's Name ____________ Date of Birth ____________ Gender ____________

Parent/Guardian #1 ____________ Parent/Guardian #2 ____________

Address ____________ Address ____________

Home Phone ____ Cell Phone ____ Work Phone ____ Home Phone ____ Cell Phone ____ Work Phone ____

Email ____________ Email ____________

☐ UMBC Faculty ☐ UMBC Staff ☐ UMBC Student *(Note: Registration fee will be applied to the first week of tuition for UMBC-affiliated families)*

Allergies (must complete an Allergy Action Plan): ____________

Does your child require any special accommodations or a lower child/staff ratio than what MSDE OCC mandates? If yes, this office will contact you prior to enrollment. ☐ Yes ☐ No

Is your child currently on an IEP or IFSP? Which services are provided? ☐ Speech ☐ Physical ☐ Occupational ☐ Other:__________
Please provide a copy of the ISP/IFSP to the director prior to your child's first day of care.

Demographic Information (Optional)

Race	☐ Black/African American	☐ Asian	☐ Hispanic/ Latino	☐ Native Hawaiian/ Other Pacific Islander	☐ American Indian/ Native American	☐ White/Caucasian	☐ Other

Household Income	☐ $0-$15,000	☐ $15,001-$24,999	☐ $25,000-$39,999	☐ $40,000-$74,000	☐ $74,001-$99,999	☐ $100,000+

Enrollment Options	Registration Fee:		2-Week Advance Payment:		Total Due:
Please note that each enrollment option is subject to availability. Fees are weekly unless otherwise noted. Service begins on Monday, August 24, 2015. Rates are effective as of August 14, 2015. Tuition rates for those with an active Y Full Family Memberships are shaded.	*Non-refundable* **$85.00**	+	$____________	=	$__________

All required paperwork is due at least 3 business days prior to your child's start date.

Classroom	2 Days/Week *Tues & Thurs*		3 Days/Week *Mon, Wed, & Friday*		Full Time *4-5 days/week*	
Room 1: Twos	**$130**	**$140**	**$155**	**$165**	**$200**	**$210**
Room 2: Older 2s/Young 3s	**$130**	**$140**	**$155**	**$165**	**$200**	**$210**
Room 3: Threes	**$120**	**$130**	**$150**	**$160**	**$195**	**$205**
Room 4: Fours	**$120**	**$130**	**$150**	**$160**	**$195**	**$205**

Enrollment Modifications: ____________

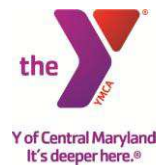
Permissions: *(Please make a selection for each)*

I give the Y Preschool permission to take photographs of my child. Please indicate whether you consent to internal sharing of the photographs, external (marketing) sharing of the photographs, both, or none.	**INTERNAL EXTERNAL BOTH NONE**
I give the Y Preschool permission to apply sunscreen to my child. I understand that I am to provide sunscreen for my child labeled with my child's name.	**YES NO**
I give the Y Preschool permission to use diapers, wipes, rash ointments, and other creams on my child, which I understand I am to provide labeled with my child's name.	**YES NO**
I give the Y Preschool permission to allow my child to sleep on a crib/cot during rest time.	**YES NO**
I give the Y Preschool permission to transport my child for emergency purposes.	**YES NO**
I am aware that the "Parent's Guide to Regulated Child Care" is located on the Y Preschool Parent Information Board and that I may request a copy of it from the preschool director or I can find this document at *www.marylandpublicschools.org/MSDE?division?Child_care/Child_care.html*.	**YES NO**

I have read and understand all of the statements shown above.

Parent/Guardian Signature ____________ Date ____________

Director/Admin. Signature ____________ Date ____________



Preschool Registration Agreement

2015-2016 School Year

Student's Name____ Date of Birth:_________________________

Parent/Guardian Name____

Please review the following information to ensure that you understand your responsibilities in enrolling your child in the Y Preschool Program. This signed agreement will be placed in your child's file and a copy provided for your records upon request.

1. I agree to pay a non-refundable registration fee at the time of enrollment. I also agree to pay for the sum of two week's tuition in advance. I understand that in order to continue my child's enrollment, each year I must pay an annual non-refundable program and curriculum fee.____**(initial)**

2. I understand that tuition is due every Friday. I understand that care may be terminated if my account is past due. A late charge of $25.00 will be applied to any account not paid in full by the due date. I understand that if my account has a history of recurring late payments (including 2 suspensions in a one-month period), then I will be held to the terms of a 'Late Payment Policy'.____**(initial)**

3. I understand that tuition prices are subject to change. Only those with an active full family Y membership are eligible for the tuition member rates (complimentary memberships do not apply). In order to receive the family member rate, the first (primary) parent/guardian on the registration form must be the first adult listed on the family membership.____**(initial)**

4. I have received a copy of the Financial Issues Statement, which explains payment policies, registration fees, tuition fees, change in care, late fees, late pick-up fees, vacation credits, and financial assistance. I have also received a Holiday Schedule and understand that payment is due for Holiday closings, sick days, emergency closings, and other absences.____**(initial)**

5. I understand that all changes in scheduled care must be made in writing through the Center Office at least two weeks in advance. Verbal notifications of changes or withdrawals cannot be accepted. There is a $10 processing fee for refunds and changes in care.____**(initial)**

6. I understand that my child must be escorted by an adult (18 years or older) to a Y staff member in the center. The adult must also sign the in/out roster to ensure that this safety regulation is enforced.____**(initial)**

7. I understand that it is my responsibility to notify the center staff of any family/medical information pertinent to my child's health, safety and well-being; and to provide updated medical records as necessary. Additionally, I will keep work and emergency contact and phone numbers up-to-date.____**(initial)**

8. If there are any custody issues, I 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. I understand 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. I understand that I must communicate with the other parent in regards to information on the care and education of my child and refrain from placing Y staff in the middle of any custody issues. Failure to do so could result in termination of care.____**(initial)**

8\. I understand that if my child is having problems adjusting to the program, a conference will be arranged between the staff and myself.____**(initial)**

9\. I understand that I may be asked to withdraw my child from the program if their behavior threatens their own safety and/or health, or that of other children and staff in the Center. If possible, a two-week period will be allowed for parents to make alternative care arrangements. For more serious offenses, I understand that I may be called immediately to pick up my child and he/she may be suspended or expelled from care without prior warnings. Some examples of this include, but are not limited to: disrupting the classroom setting, hitting, punching, kicking, or biting another student or teacher. Credit is not issued for days of suspension.____**(initial)**

10\. I understand that care may be terminated if my behavior does not fit within the core values of the Y; if I do not follow Y policies; or if I become aggressive toward any Y staff, parents, or children.____**(initial)**

11. If my child becomes ill or if a medical emergency arises, the staff will first attempt to contact me and I will be required to pick my child up within an hour of receiving the call. If I cannot be reached, emergency contacts and/or my child's doctor will be contacted.____**(initial)**

12. I understand that my child 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. I understand that my child must be symptom free (vomiting, fever, and diarrhea) for at least 24 hours before returning to the Center. Additionally, a doctor's release will be required in order for my child to return to the center after a contagious illness. I have reviewed the health policy as provided in the Y Parent Handbook, which explains the Maryland State Health Department's requirements on medication, periods of infection, attendance, and immunization.____**(initial)**

13. I understand that an alternate care plan must be made in advance for illness and emergency closings. I also understand that I am still required to pay should these situations arise.____**(initial)**

14. I understand that I must speak to the director in advance if I'd like to bring cupcakes to share with the class to recognize my child's birthday. I also understand that hats, balloons, presents, goody bags, horns, etc. are not allowed in the preschool as they cause distractions and possible safety risks to the children in care.____**(initial)**

15. I will not allow my child to bring in toys, money, books, jewelry, candy, or any other treasures from home. I understand that my child may only bring toys and books from home on specified 'show-n-tell' days.____**(initial)**

16. I give permission for my child to participate in walks within the grounds of the Center.____**(initial)**

17. I give permission for my child to participate in the Y instructional swim classes (if applicable)and water play days as part of the program.____**(initial)**

18. I give permission for my child to be transported by the use of Y buses (if applicable). I also understand that I will receive a permission slip to sign for any field trips off of the center grounds.____**(initial)**

19. If my child deliberately destroys Y (or school) property, I understand that I will be held responsible for the replacement cost of the property.____**(initial)**

20. I understand that my child may be exposed to classroom pets in the preschool center, including but not limited to fish, guinea pigs, hamsters, gerbils, rabbits, and other small animals.____**(initial)**

21. By signing this agreement, I acknowledge that I am the responsible party for payment of all fees and tuition.____**(initial)**

22. I understand that I must allow at least 5 business days for any paperwork requests.____**(initial)**

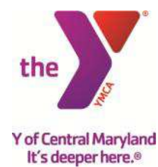
23. I have received and read a copy of the Y Parent Handbook.____**(initial)**

My signature indicates I have read and understand the Preschool Registration 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.

Student's name:___________________________________ Site:___________________________________ Date:________

Parent's name:____ Date:________________________________

Parent's signature:____ Date:_________________________



Preschool Financial Issues Statement

2015-2016 School Year

Child's Name____ Date of Birth:_________________________

Parent/Guardian Name____

The Y is a non-profit 501 (c)3 organization. Our rates are reflective of our actual costs in providing comprehensive, quality-based care. Please support our efforts to keep costs down by adhering to the policies and procedures for these services.

Tuition Fees

Registration must be done each year and an annual registration fee must be paid. Payment for tuition is due every Friday. Only those with an active full family Y membership are eligible for discounted preschool tuition rates. Membership discounted rates are not applicable for complimentary membership offers. In order to receive the family member rate, the first (primary) parent/guardian on the registration form must be the first adult listed on the family membership.

Payment Policies

Payment can be made by check, money order, or credit card. Please put your child's name on the check or money order. We offer the option of having your credit card number on file and automatically charging it for each tuition payment - EFT (Electronic Funds Transfer) payment method, or you may pay online. Make check or money order payable to the Y of Central Maryland. Mail your payment to the Billing Office, or make payment at the membership desk at your local Y Health and Wellness Center. A receipt will be provided only upon request.

Late Payment Policy

A late charge of $25 will be applied to any account not paid in full by the due date. If payment is late, then parents will receive either a note or a phone call concerning late payments and a date for termination of services if payment is not received. To avoid disruption of service, payment must be made in full by the final termination date; and you must provide receipt of payment to the center director or opening staff before your child will be admitted into care. Personal checks will not be accepted on delinquent accounts or if a personal check has been refused for payment (NSF-non sufficient funds) by our financial institution within the last 12 months. Any accounts with a history of recurring late payments (including 2 suspensions in a one-month period), will be held to the terms of a 'Late Payment Policy'.____(initial)

Bad Checks

Checks that are returned for non-payment will not be re-deposited. An additional charge of $25.00 will be charged for any returned checks. We will notify you by phone or letter of a Non-Sufficient Funds occurrence. The $25.00 fee will be added to your next payment. Multiple returned checks may result in the Y not being able to accept personal checks for payments.

Change in Tuition

Tuition fees are subject to change. Written notice will be given in advance regarding such a change. If your child needs to have any changes in their enrollment, request must be made in writing two weeks in advance. Verbal changes cannot be accepted. There is a $10.00 processing fee for refund or change in care requests.

Credits

There is no reduction in fees if a child is absent from the program or if the site is forced to close due to circumstances beyond our control. A vacation credit of one week per year (September through August) may be used if your child is absent for five consecutive days (Monday-Friday) for a family vacation. This credit only applies to those children that have been enrolled in the program full-time for at least 6 months or more. Written notice must be given at least two weeks in advance to use this credit. Notice should be given directly to the preschool director for approval and delivery to the billing office.

Late Pick-Up Charge

Late fees begin at the close of business and are assessed as follows: $5.00 for the first five minutes and $5.00 for each 5-minute period thereafter or fraction thereof. Parents who are late will be presented with a Late Charge Slip, and asked to sign/verify the late balance being assessed. Parents are responsible for paying the accrued late charges by the close of the next business day. (Regulations require that two staff members must stay at the center until every child is picked up. Staff who work overtime are required to be paid time and a half salary.) Please remember that late parents must call the center to inform the staff of the delay. Ten minutes after the close of business, emergency contacts will be notified to arrange pick-up of the child. If we can not reach either you or your emergency contacts to pick up your child, then we will contact Child Protective Services. Parents with excessive, unexcused, late pick-ups will be given notice to find alternate care.

Financial Assistance

Financial Assistance may be available to qualifying families. Verification of income is required and applications are renewed and reviewed on a quarterly basis. Applications are available from the business office.

I have read and understand the above.

Parent/Guardian's Signature: ____ Date: _______________

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

PRESCHOOL (Weekly, Fridays from Begin Date to 8/5/2016) ☐ **Service Location:** ____________________

Before and After School Enrichment/CHIPS ☐

(Monthly, 1st day of month from Begin Date to 5/1/2016)

Account information, please print:

Child's Name ________________________________ Phone (Home) ____________________

Cardholder's Name ________________________________ Phone (Work) ____________________

Member # ________________________________ Phone (Cell) ____________________

Street Address ________________________________ Email receipts to: ____________________________

City, State, Zip

Payment information:

Billing Method (Circle one): VISA MASTERCARD AMEX DISCOVER

Account Number: ________________________________

Expiration (Month/Year) ________________________________

Security code (back of card) ________________________________

Preschool - Begin Date: ____________________

Weekly Amount: $ ____________________

BASE - Begin Date: ____________________

Monthly Amount: $ ____________________

CREDIT CARD ELECTRONIC FUND TRANSFER AUTHORIZATION AND AGREEMENT

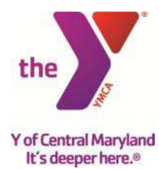
TO THE Y OF CENTRAL MARYLAND (herein referred to as the Y): I have given my authority to charge the above named credit/debit card for the activity payments indicated above. It is understood that the Y's transmission of the EFT to the card issuer as payment becomes due and shall constitute valid notice 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/BASE 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 (print): ________________________________

Customer Signature: ________________________________ Date: ____________________



Preschool Online Payment Instruction Page

2015-2016 School Year

Online Payment Instructions

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

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.

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.

Preschool School Year 2015-2016

PAYMENT INFORMATION PAGE

2015-2016 Payment Schedule

	For the weeks of...		Payment is due...
1	Monday, August 24, 2015	--------	Friday, August 14, 2015
2	Monday, August 31, 2015	--------	Friday, August 21, 2015
3	Monday, September 7, 2015	--------	Friday, August 28, 2015
4	Monday, September 14, 2015	--------	Friday, September 4, 2015
5	Monday, September 21, 2015	--------	Friday, September 11, 2015
6	Monday, September 28, 2015	--------	Friday, September 18, 2015
7	Monday, October 5, 2015	--------	Friday, September 25, 2015
8	Monday, October 12, 2015	--------	Friday, October 2, 2015
9	Monday, October 19, 2015	--------	Friday, October 9, 2015
10	Monday, October 26, 2015	--------	Friday, October 16, 2015
11	Monday, November 2, 2015	--------	Friday, October 23, 2015
12	Monday, November 9, 2015	--------	Friday, October 30, 2015
13	Monday, November 16, 2015	--------	Friday, November 6, 2015
14	Monday, November 23, 2015	--------	Friday, November 13, 2015
15	Monday, November 30, 2015	--------	Friday, November 20, 2015
16	Monday, December 7, 2015	--------	Friday, November 27, 2015
17	Monday, December 14, 2015	--------	Friday, December 4, 2015
18	Monday, December 21, 2015	--------	Friday, December 11, 2015
19	Monday, December 28, 2015	--------	Friday, December 18, 2015
20	Monday, January 4, 2016	--------	Friday, December 25, 2015
21	Monday, January 11, 2016	--------	Friday, January 1, 2016
22	Monday, January 18, 2016	--------	Friday, January 8, 2016
23	Monday, January 25, 2016	--------	Friday, January 15, 2016
24	Monday, February 1, 2016	--------	Friday, January 22, 2016
25	Monday, February 8, 2016	--------	Friday, January 29, 2016
26	Monday, February 15, 2016	--------	Friday, February 5, 2016
27	Monday, February 22, 2016	--------	Friday, February 12, 2016
28	Monday, February 29, 2016	--------	Friday, February 19, 2016
29	Monday, March 7, 2016	--------	Friday, February 26, 2016
30	Monday, March 14, 2016	--------	Friday, March 4, 2016
31	Monday, March 21, 2016	--------	Friday, March 11, 2016
32	Monday, March 28, 2016	--------	Friday, March 18 2016
33	Monday, April 4, 2016	--------	Friday, March 25, 2016
34	Monday, April 11, 2016	--------	Friday, April 1, 2016
35	Monday, April 18, 2016	--------	Friday, April 8, 2016
36	Monday, April 25, 2016	--------	Friday, April 15, 2016
37	Monday, May 2, 2016	--------	Friday, April 22, 2016
38	Monday, May 9, 2016	--------	Friday, April 29, 2016
39	Monday, May 16, 2016	--------	Friday, May 6, 2016
40	Monday, May 23, 2016	--------	Friday, May 13, 2016
41	Monday, May 30, 2016	--------	Friday, May 20, 2016
42	Monday, June 6, 2016	--------	Friday, May 27, 2016
43	Monday, June 13, 2016	--------	Friday, June 3, 2016
44	Monday, June 20, 2016	--------	Friday, June 10, 2016
45	Monday, June 27, 2016	--------	Friday, June 17, 2016
46	Monday, July 4, 2016	--------	Friday, June 24, 2016
47	Monday, July 11, 2016	--------	Friday, July 1, 2016
48	Monday, July 18, 2016	--------	Friday, July 8, 2016
49	Monday, July 25, 2016	--------	Friday, July 15, 2016
50	Monday, August 1, 2016	--------	Friday, July 22, 2016
51	Monday, August 8, 2016	--------	Friday, July 29, 2016
52	Monday, August 15, 2016	--------	Friday, August 5, 2016

4 Easy Ways to Make a Payment

1. Online payment options are available via our website at www.ymaryland.org. See our Online Payment Instructions Page in this packet for more details.

2. For automatic billing, complete an EFT form (enclosed) and return it to the Billing Office.

3. Mail checks to the Customer Billing Office. See below for mailing address.

4. Call-in to the Customer Billing Office for over-the-phone credit card payments. See below for telephone number.

If full payment is not received by the Monday of the week of care, a late fee of $25 will be assessed to your account. If payment is still outstanding on Tuesday, your care will be suspended until the full tuition plus late fee is received. Contact the customer billing office immediately about special billing arrangements.

Payments cannot be given to staff.

We accept payments via money orders, American Express, Discover, MasterCard, and VISA. The Y will gladly accept your personal check; however, there will be a $25 charge for any check returned to the Y unpaid by your bank.

Customer Billing Office/Contact Information

303 West Chesapeake Avenue
Baltimore, MD 21204
Hours: 8:00 am – 5:30 pm
(p) 443-322-8000 option #1
(f) 410-779-9426
Email: billing@ymaryland.org

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name ________________________________ Birth Date ______________
Last First

Enrollment Date ______________ Hours & Days of Expected Attendance ______________

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: ______________ W:	C:	H:
		Place of Employment: ______________ W:	C:	H:

Name of Person Authorized to Pick Up Child *(daily)* ________________________________
Last First Relationship to Child

Address ________________________________
Street/Apt.# City State Zip Code

Any Changes/Additional Information ________________________________

____

ANNUAL UPDATES ______________ ______________ ______________ ______________
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name ________________________________ Telephone (H) ______________ (W) ______________
Last First

Address ________________________________
Street/Apt.# City State Zip Code

2. Name ________________________________ Telephone (H) ______________ (W) ______________
Last First

Address ________________________________
Street/Apt.# City State Zip Code

3. Name ________________________________ Telephone (H) ______________ (W) ______________
Last First

Address ________________________________
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care ________________________________ Telephone ______________

Address ________________________________
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian ________________________________ Date ______________

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ____________________

Medical Condition(s): ____

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________________

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ____

____

(2) If signs/symptoms appear, do this: ______________________________________

(3) To prevent incidents: ____

____

- -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ________________

____

____

____

COMMENTS: ____

____

____

____

____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ ______________________________
Name of Health Practitioner Date

______________________________ (_____)________________________
Signature of Health Practitioner Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- ***A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations**. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:* http://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: ______ Last First Middle **Birth date:** ______ Mo / Day / Yr **Sex** M☐ F☐

Address: ______ Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

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
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
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

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

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

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

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781

Prince George's (cont)
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

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 Mo/Yr
1									1				
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)

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 <u>immediately</u> 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: ______________________________

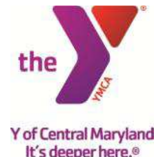
Child: ______________________________

Child: ______________________________

I, ______________________________, have received a copy of the consumer education brochure entitled "Parent's Guide to Regulated Child Care."

____
Date

____
Signature of Parent/Guardian



Preschool Allergy Emergency Care Plan

2015-2016 School Year

My child ______________________________ does/does not have an allergy.
Child's name (circle one)

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

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

Parent/Guardian signature:____ Date:____________

Allergy Action Plan

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

Place Child's Picture Here

CHILD'S NAME: ______________________ Date of Birth: ____________

ALLERGY TO: ______________________

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

TREATMENT

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

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

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

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

Doctor's Signature ______________________ Date ____________

EMERGENCY CALLS

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

Doctor's Name:______________________ Phone Number:____________

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

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

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

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

Parent/Guardian's Signature ______________________ Date ____________

Allergy Action Plan
(Continued)

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

Place Child's Picture Here

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

ALLERGY TO: ______________________

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

The Child Care Facility will:

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

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

©2010 Dey Pharma, L.P. All rights reserved.
DEY® and the Dey logo are registered trademarks of Dey Pharma, L.P.
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

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

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

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

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

Symptoms	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

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

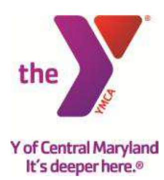
Medication was received by: ______________________
Signature of Person Receiving Medication and Reviewing the Form — Date

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



Preschool Enrollment and Liability Release/Medical Information

2015-2016 School Year

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 of 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 of 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 of 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 of 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)

____

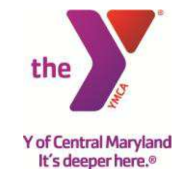
____

Physician name ____ telephone_____________________

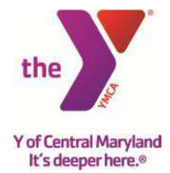
Physician address____

Emergency Contact ____ telephone_____________________

Emergency Contact ____ telephone_____________________



www.ymaryland.org

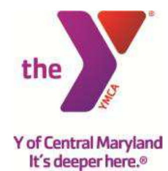


Preschool Holiday Closing Schedule

2015-2016 School Year

Monday, September 7	Labor Day	Closed
Thursday, November 26	Thanksgiving	Closed
Friday, November 27	Thanksgiving Holiday	Closed
Thursday, December 24	Christmas Eve	Closed
Friday, December 25	Christmas Day	Closed
Friday, January 1	New Year's Day	Closed
Monday, January 18	MLK, Jr. Holiday	Closed
Friday, March 25	Good Friday	Closed
Monday, May 30	Memorial Day	Closed
Monday, July 4	Independence Day	Closed

Note: The Y Preschool will be closed for one week in August 2016 for teacher training and classroom preparations for the next school year. Dates will be announced ASAP.



Preschool Complimentary Membership Letter

2015-2016 School Year

Dear Parents,

At the Y of Central Maryland – we focus on Family Care. What sets the Y apart from other preschool programs includes our commitment to strengthen family life. Y programs strive to support and assist parents, to strengthen parent-child relationships, and to increase the importance of families. As Maryland's largest provider, we're committed to helping families relieve the stress of balancing work and family.

In an effort to support and enhance opportunities for families to play and stay active and healthy together the Y of Central Maryland extends a **three-month, complimentary Family Membership to new families enrolled full time*** at one of our preschool centers. You are eligible to receive all of the benefits of a Family Membership; excluding discounts on summer camp and tuition fees. We hope that you will take full advantage of this opportunity with free and discounted access to a wide range of programs such as swim lessons, yoga, Pilates, personal trainers, dance classes, martial arts, sports teams, family fun events and more. Once you realize the benefit to you and your family, we hope that you will consider joining the Y of Central Maryland after your complimentary period.

To activate your complimentary membership, please take this letter to the Y Center most convenient to you. The Member Service Representative will orient you to the Y and give you your membership card.

Welcome to the Y of Central Maryland. I hope that this is just the beginning of our relationship with you and your family.

Sincerely,

John Hoey
President and CEO
Y of Central Maryland

* Full time enrollment is considered 5 full days per week.

Name of full-time student____

Y Preschool Program______________________________ Registration date_______________

Deadline for activating complimentary membership______________________________

Signature of Preschool Director______________________________ Updated 3/2015

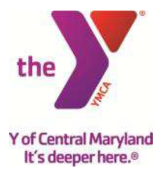
~Office Copy~

Name of full-time student____

Y Preschool Program______________________________ Registration date_______________

Deadline for activating complimentary membership______________________________

Signature of Preschool Director______________________________ Updated 3/2015



Preschool Disclaimer - Lost and Stolen Items

2015-2016 School Year

Attention Parents

Lately, we've noticed that more and more children are bringing toys, money, books, jewelry, candy, and other treasures from home in to the center. These items can be easily lost or misplaced; and, even more importantly, some can pose a health risk for children (i.e., choking hazard).

Our number one priority at the Y is to provide a safe and nurturing academic environment for children. As such, please **do not** allow your child to bring in any items from home. Our classrooms are well equipped with a variety of safe, age-appropriate materials that your child can use and enjoy throughout the day.

Occasionally, the teachers plan special show-and-tell days. You will be notified if your child's class is participating in show-and-tell. Only in these instances will a child be permitted to bring in an item from home.

In addition, please be sure to label your child's clothing, lunch box, cot items, and winter-wear.

The Y of Central Maryland is not responsible for lost, misplaced, or stolen items.

Thank you for your cooperation and your continued support of our programs.