Camp Jordan

Enrollment Forms

5-12 Year Old Summer Camp Program
Camp Jordan Checklist

Camper’s Name: _________________________________

Please place forms in order of list:

Enrollment Date: ________________________________

☐ Enrollment form with copy of Wor-Wic Community College class schedule (OCC 1214)
☐ Wor-Wic Community College Application for Summer Program
☐ Emergency Contact Form
☐ Health Inventory Form: Part I & II (OCC 1215), Medication Authorization (OCC 1216)
☐ Parent/Guardian Authorization Form
☐ Consent Form (Handbook, Photo, Allergy, Communicable Disease Summary)
☐ USDA Food Program CACFP
☐ Parent’s Guide to Regulated Child Care Card Authorization Form

Entered by staff: ______________________________________________

_____________________________________________________________

☐ ProCare Windows:
☐ Basic Information
☐ Contacts
☐ Schedule
☐ Medical
☐ Consent forms
☐ Contact Photo

Fees Paid:
☐ Deposit Fee $ 25.00 (non-refundable)
☐ $________ First week deposit

Camp registration is contingent upon receipt of all required completed enrollment documentation and payment of fees prior to the first week of camp.

Parent Signature: __________________________________________ Date: _______________

Administrator’s Signature: ________________________________ Date: _______________
Wor-Wic Camp Jordan

REGISTER YOUR 5-12 YEAR OLD FOR THESE PROGRAMS TODAY THRU MAY 9, 2014!!!

SUMMER PROGRAM DATES & TIMES

June 16 - August 22, 2014
Monday-Friday, 7:30 a.m. - 5:30 p.m.
Weekly Full-time Sessions!

<table>
<thead>
<tr>
<th>Weekly Camp Fees</th>
<th>Check the Weeks Attending</th>
<th>Session</th>
<th>Dates</th>
<th>Theme</th>
<th>Field Trip</th>
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<tr>
<td>$145.00 Per Week</td>
<td>□</td>
<td>Week 1</td>
<td>June 16-20</td>
<td>Spirit Week</td>
<td>Swimming</td>
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<tr>
<td>$145.00 Per Week</td>
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<td>Week 2</td>
<td>June 23-27</td>
<td>5 Days of Tasting</td>
<td>Crown Skating Center</td>
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<td>$116.00 Per Week</td>
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<td>Week 3</td>
<td>June 30-July 3 *</td>
<td>America the Beautiful</td>
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<tr>
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<td>Week 4</td>
<td>July 7-11</td>
<td>Gizmos, Gadgets, and Goop</td>
<td>Delmarva Discovery Center</td>
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<td>Get in the Game</td>
<td>Jane’s Island &amp; Millard Tawes/ Swimming</td>
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<td>Outer-Space</td>
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<td>Week 10</td>
<td>August 18-22</td>
<td>STEM-nAtion</td>
<td>Friends Forever &amp; Ocean Resorts Golf Club</td>
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Deposit Fee: $25.00 (non-refundable) due with enrollment application

Discounts for Wor-Wic Students and Employees
### Camp Jordan

**Application for Summer Program**

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<th>Child’s First &amp; Last Name</th>
<th>Birth date</th>
<th>Age</th>
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<th>Female</th>
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### Please select the appropriate status:

- ☐ Wor-Wic Community College Student
- ☐ Wor-Wic Community College Employee
- ☐ Community Member

**Name of School Child(ren) attend:**

**Phone Number of School:**

---

**Camp Jordan offers weekly full time sessions.**

You can sign up for one or more weeks, or the entire summer!

**June 16 to August 22, 2014.**

Application deadline and first week deposit are due by **May 9, 2014**

**Call for questions: 410-334-2962**

A CAMPER MAY NOT START AT THE CENTER UNTIL ALL FORMS ARE SUBMITTED AND FEES ARE PAID IN FULL.
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.

When parents 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’s Name _________________________________________________________________ Home Telephone _____________________________
   Last     First

Mother’s Employer/School _______________________________________________________________________________________________________
   Name      Address

Mother’s Home Address (If different from above) _________________________________________________________________________________________
   Street/Apt.#    City    State  Zip Code

Work Telephone _________________________________ Cellular Phone ___________________________ Beeper _____________________________

Father’s Name _________________________________________________________________ Home Telephone _____________________________
   Last     First

Father’s Employer/School _______________________________________________________________________________________________________
   Name      Address

Father’s 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

ANNUAL UPDATES

(Initials/Date)  (Initials/Date)  (Initials/Date)  (Initials/Date)

OCC 1214 (Revised 7/05) - Side 1 of 2 - All previous editions are obsolete.
INSTRUCTIONS TO PARENT:
(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
...........................................................
Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child’s Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _________________________________________________________

Address: _______________________________________________________________________

City/Town __________________________ State _______________ Zip Code ____________________
## PART I: CHILD’S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN**

| CHILD’S NAME: _________________________ |

**IMPORTANT:** COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for “REMARKS”.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

1. Are you concerned about your child’s general health (eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?  
   - Date of last eye examination: ____/____/____  
   - Doctor’s Name: ___________________________  
   - Results: _____________________________________________________________________________________  
   - Does your child wear glasses?  
   - Contact lenses?  

2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes)?  
   - Date of last hearing evaluation ____/____/____  
   - Doctor’s Name: ___________________________  
   - Results: _____________________________________________________________________________________  
   - Does your child use a hearing aid?  

3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, etc.)?  
   - Date of last hearing evaluation ____/____/____  
   - Doctor’s Name: ___________________________  
   - Results: _____________________________________________________________________________________  
   - Does your child use a hearing aid?  

4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)?  

5. Does your child have any allergies? If YES, please state what kind of allergies:  

6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:  
   - (a) Does this condition require any special health care in the child care facility?  
   - (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?  
   - (c) Does your child require any special adaptations or adaptive equipment?  

7. Do you have concerns about your child’s behavior or emotional well-being which the child care provider or teacher should know about?  

8. Do you have concerns about your child’s social or developmental needs which the child care provider or teacher should know about?  

**REMARKS** *(Provide further explanation for all “YES” answers):*  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  

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: MEDICAL INFORMATION

To be completed by a HEALTH PRACTITIONER

CHILD’S NAME: ________________________________

1. Date of this child's most recent tuberculin test: ___/___/___  Result: ____ Positive    ____ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child’s lead screening:   ___/___/___  Blood lead test dates: Test 1: ___/___/___  Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)
   a. Vision problem □YES □ NO
   b. Hearing problem □YES □ NO
   c. Speech or language problem □YES □ NO
   d. Other physical illness or impairment □YES □ NO
   e. Mental, emotional or behavior problems □YES □ NO
   f. Developmental delays □YES □ NO
   g. Allergies □YES □ NO

   Significant physical findings, comments and recommendations:

4. This child has a health condition which may require care or emergency action while at child care. □YES □ NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.):

Recommendations:

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school. □YES □ NO  If YES, please specify:

6. This child requires a modified diet and/or special feeding procedures. □YES □ NO

If YES, please specify:

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

____________________________________________________________________________________________________________

8. Does this child's physical activity need to be restricted? □YES □ NO

If YES, please specify:

9. Does this child require any specialized treatment? □YES □ NO

If YES, please specify:

10. Does this child require any adaptive equipment (braces, crutches, etc.)? □YES □ NO

If YES, please specify type:

Special instructions for use:

RECORD OF IMMUNIZATIONS

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<th>Vaccine Types</th>
<th>Dose #</th>
<th>DTP-DTAP</th>
<th>Polio</th>
<th>HIB</th>
<th>Hep B</th>
<th>PCV7</th>
<th>MMR</th>
<th>Varicella</th>
<th>Rotavirus</th>
<th>MCV4</th>
<th>HPV</th>
<th>Hep A</th>
<th>Other</th>
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OCC 1215 - Revised 6/08 - All previous editions are obsolete and replaces OCC 1215A, OCC 8506 and use of DHMH 896.
PART II: MEDICAL INFORMATION (CONTINUED)

Child’s Name ____________________________________________

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a ☐ permanent ☐ temporary condition until ___/____/____. Check appropriate box, indicate vaccine(s) and reasons: __________________________________________________________ 
_____________________________________________________________________________________________________________________________________

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she IS / IS NOT medically cleared to attend child care. (circle correct response)

Signature of Health Practitioner ____________________________________________
Date ____________________________ Phone Number ____________________________

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

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

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<th>Baltimore (cont)</th>
<th>Carroll</th>
<th>Frederick (cont)</th>
<th>Montgomery</th>
<th>Prince George's (cont)</th>
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OCC 1215 - Revised 6/08 - All previous editions are obsolete and replaces OCC 1215A, OCC 8506 and use of DHMH 896.
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 Name: ________________________________ | Date of Birth: ________________________________ |
| Condition for which medication is being administered: ________________________________ |
| Medication Name: ________________________________ | Dose: ________________________________ | Route: ________________________________ |
| Time/frequency of administration: ________________________________ | If PRN, frequency: ________________________________ |
| If PRN, for what symptoms: ________________________________ |
| Possible side effects - Specify: ________________________________ |
| Medication shall be administered from: ________________________________ to ________________________________ |
| Prescriber’s Name/Title: ________________________________ | (Type or print) |
| Telephone: ________________________________ | FAX: ________________________________ |
| Address: ________________________________ |
| Prescriber’s Signature: ________________________________ | Date: ________________________________ |

This space may be used for the Prescriber’s Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I/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.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Medication Name:</td>
<td>Dosage:</td>
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<tr>
<td>Route:</td>
<td>Time(s) to administer:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>DOSAGE</th>
<th>REACTIONS OBSERVED (IF ANY)</th>
<th>SIGNATURE</th>
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The following are AUTHORIZED people who MAY sign for this camper (a photo is needed for each person listed):

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<tr>
<th>Name</th>
<th>Phone #</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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The following are UN-AUTHORIZED people and MAY NOT sign for this camper:

1. 

2. 

PARENT/GUARDIAN AUTHORIZATION FOR WOR-WIC COMMUNITY COLLEGE CHILD CARE AND RELATED PROGRAMS

The person described herein has my permission to participate and engage in child care activities.

I understand the fee structure for Wor-Wic Community College child care programs, and will pay according to the prescribed payment plan unless prior written agreement has been made with the cashier’s office.

I give my permission to Wor-Wic Community College, without obligation to me, to use any photographs, film footage, tape recordings which may include my child’s image or voice for purposes or promoting or interpreting Wor-Wic Community College Child Care programs.

The terms herein shall serve as the parent/guardian authorization release, and assumption of risks for claims arising from incidents surrounding child care programs for my child, myself, my spouse, my heirs, executor, administration, assignees, and for all other members of my family.

Signature of Parent or Guardian ___________________________ Date ___________________________
Consent Form  
Parent Handbook, Photo Release, Allergy Notice, and Communicable Disease Summary

Handbook
Child Development Center Handbook is located at www.worwic.edu under Child Development Center home page. Click the Parents Manual link to access the handbook. I have read and understand the contents of this handbook. I understand that I am aware of my responsibility for supplying all necessary information regarding my child and that I must continually update this information. I am also aware that I will be notified of any revisions of this handbook through my child’s class mailbox.

___________________
Initials

Photo Release
I hereby consent to having my child(ren)'s photograph or myself used for publicity purposes by Wor-Wic Community College. I understand that the photographs may be used at any time for a variety of publicity purposes, including, but not limited to, classroom observations, news release to newspapers, television commercials and college publications such as the catalog, program brochures or website.

___________________
Initials

Allergy Notice
I have read and understand the letter regarding nut allergies in the Child Development Center. I understand that until further notice is given this will effect any lunches or snack I as a parent or guardian provide. I understand that this is in effect for Tuesdays and Thursdays. If I have any questions about a product I am providing I will seek the help of the Center Staff. Labels are provided for any suspected products.

___________________
Initials

Communicable Disease Summary
I have received a copy of the Communicable Disease Summary in the enrollment forms provided by the Child Development Center. I understand that this summary is presented by the state of Maryland.

___________________
Initials

I certify that I have read the above information and any reference material stated.

Date:
Signature of Parent/Guardian
**FREE AND REDUCED-PRICE MEAL BENEFIT APPLICATION**

**CHILD CARE CENTERS:** July 1, 2013 – June 30, 2014

Complete this form so that we may receive reimbursement for meals served to children in our program. For help call ____________________________.

PART 1 – ENROLLED CHILDREN INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Check (✓) if foster child</th>
<th>If completed, skip to Part 5.</th>
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PART 2 - CASE NUMBER

If applicable, give a Food Supplement Program or Temporary Cash Assistance case number for any member of the household.

If completed, skip to Part 5. Last four digits of Social Security Number are not needed.

PART 3 - IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND COMPLETE THE APPLICATION ☐ HOMELESS ☐ MIGRANT ☐ RUNAWAY

PART 4 - HOUSEHOLD MEMBERS AND GROSS INCOME. You must tell us how much and how often.

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<thead>
<tr>
<th>LIST NAMES OF ALL HOUSEHOLD MEMBERS</th>
<th>EARNINGS FROM WORK (before deductions)</th>
<th>ADDITIONAL INCOME</th>
<th>ALL OTHER INCOME</th>
<th>Check if NO income</th>
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PART 5 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. If Part 4 is completed, the adult signing the form must list the last four digits of his/her Social Security Number, or mark the “I do not have a Social Security Number” box. (See Privacy Act Statement)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give. I understand that center officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: ____________________________ Print name: ____________________________ Date: ____________________________

Address: ____________________________ Phone Number: ____________________________

City: ____________________________ State: _______ Zip Code: ____________________________ Social Security Number: XXX-XX- ___ ___ ___ ☐ I do not have a SSN

PART 6 - (OPTIONAL) CHILDREN'S ETHNIC AND RACIAL IDENTITIES:

Choose one ethnicity: ☐ Hispanic/Latino ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ Not Hispanic/Latino ☐ White ☐ Native Hawaiian or other Pacific Islander

PART 7 - SHARING INFORMATION WITH OTHER PROGRAMS

Information that you provide will be used to determine your children’s eligibility for free or reduced-price meals. The eligibility status of your children may also be used for other authorized purposes. Your family may be eligible to receive benefits under the Food Supplement Program (FSP) or the Women, Infants, and Children (WIC) Program.

To share your information with these programs, we must have your permission. Your decision will not change whether your children receive free or reduced-price meals. If you want information shared with FSP or WIC, check (✓) the YES box below. You may be contacted about submitting an application for the FSP or WIC.

☐ YES, I want information shared from the Free and Reduced-Price Meal Benefit Application with ☐ FSP and/or ☐ WIC

Children eligible for free or reduced-price school meals may also be able to get free or low-cost health insurance through Medicaid or the MD Children's Health Insurance Program (MCHIP). The law allows us to inform Medicaid and MCHIP that your children are eligible for free or reduced price meals, unless you say No. Your decision will not change whether your children receive free or reduced-price meals.

If you do not want information shared with Medicaid or MCHIP, check (✓) ☐ No.

**DO NOT FILL OUT THIS PART. THIS IS FOR CENTER USE ONLY.**

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

Total Income: ____________________________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice A Month ☐ Month ☐ Year Household size: ________ Date Withdrawn: ____________________________

Eligibility: Free (Categorically Eligible: ___ ) Reduced ___ Denied ___ Reason: ____________________________

Determining Official’s Signature: ____________________________ Date: ____________________________
CAMP JORDAN ENROLLMENT FORM

Name of Center: Wor-Wic Community College Jordan Child Development Center

Camper(s): Circle Days In Care Circle Meals Served

Name: _____________________________________ M T W TH F SA S B AM L PM S Snack Snack

Name: _____________________________________ M T W TH F SA S B AM L PM S Snack Snack

Name: _____________________________________ M T W TH F SA S B AM L PM S Snack Snack

Name: _____________________________________ M T W TH F SA S B AM L PM S Snack Snack

Address of Parent/Guardian:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Telephone Number: ________________________________

Printed Name of Parent/Guardian ___________________________ Signature ___________________________

Date Signed ___________________________

In accordance with federal law and U.S. Department of Agriculture policy, State law, and the Maryland State Department of Education policy, discrimination is prohibited on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to the USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

*ANNUAL UPDATES: _____________ _____________ _____________ _____________

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

*Note: This information must be updated annually. If there are no changes to report, have the parent/guardian initial and date above. If there are changes to report, a new form must be completed.

Rev 4/05
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 Child Care Administration (CCA), an agency of the Maryland Department of Human Resources. It is CCA’s responsibility to ensure that safe child care is available to Maryland families.

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 CCA at least once each year to evaluate the facility’s compliance with child care regulations.

CCA’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 CCA, 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 CCA 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. Credential holders are authorized and encouraged to display the seal issued by the Child Care Administration.

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 CCA 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
One Market Center
300 West Lexington Street, Box 10
Baltimore, MD 21201
Phone: (410) 333-3688
www.md-council.org

Important Information for Parents of Children in Child Care Facilities
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 CCA 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 must have a criminal background check and a child abuse/neglect clearance. Paid staff members must also have criminal background checks. All employees must 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:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Ratio</th>
<th>Maximum Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 –18 months</td>
<td>1:3</td>
<td>6</td>
</tr>
<tr>
<td>18 – 24 months</td>
<td>1:3</td>
<td>9</td>
</tr>
<tr>
<td>2 years</td>
<td>1:6</td>
<td>12</td>
</tr>
<tr>
<td>3 –4 years</td>
<td>1:10</td>
<td>20</td>
</tr>
<tr>
<td>5 years or older</td>
<td>1:15</td>
<td>30</td>
</tr>
</tbody>
</table>

- 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 the care your child receives meets the standards set by Maryland child care regulations (NOTE: the regulations are available online at www.dhr.state.md.us/cca/license/regu.htm);
- 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 CCA if you believe that the caregiver has violated child care regulations.

Any complaint you make to CCA about the care your child is receiving will be promptly investigated by CCA:
- 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 CCA 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
   410-554-0457
3. Baltimore County
   410-583-6200
4. Prince George’s County
   301-333-6940
5. Montgomery County
   240-314-1401
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
   Caroline, Dorchester, Kent, Queen Anne’s and Talbot Counties
   410-819-5801
9. Lower Shore
   Somerset, Wicomico, and Worcester Counties
   410-543-6731
10. Southern Maryland
    Calvert, Charles and St. Mary’s Counties
    410-272-5358
    Cecil and Harford Counties
    301-696-9766
11. North Central
    Frederick County
    301-751-5438

The CCA 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 CCA Office of Licensing.

Director of Licensing
Child Care Administration
311 West Saratoga Street, 1st Floor
Baltimore, MD 21201
410-767-7805
www.dhr.state.md.us/cca/license

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

A PARENT’S GUIDE TO REGULATED CHILD CARE
Dear Parents,

There are children in our center who have life-threatening allergies to peanuts. Children with peanut/nut allergies cannot eat, touch, or even inhale nut products. The reaction can be deadly.

We are asking for your help in reducing the risk of reaction by washing your children’s hands and lips, and brushing their teeth after eating peanut butter or products with nuts before school.

Please do not send in foods that:

- Have peanuts/nuts in the ingredient list
- Has a warning that they may contain traces of peanuts/nuts
- Has a warning that they are manufactured on equipment or in a plant that processes peanuts/nuts

We realize that this is a lot to ask, and it may be an inconvenience for you. We are asking however, that you try to understand the danger. Something as simple as a cookie, a piece of candy, or touching a smear of peanut butter left behind, could be deadly.

Thank you very much for your cooperation.

Sincerely,

Wor-Wic Child Development Center Staff