**Before & After Care for Summer Scholars ’17**

**SUMMER SCHOLARS PROGRAM DATES & TIMES**

July 10-August 4, 2017  
Monday-Friday  
Before Care: 7:30–8:45 a.m. – Cost: $15/week  
After Care: 4:00-5:30 p.m. – Cost: $20/week  
Both Sessions: Cost: $30/week

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date</th>
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<tr>
<th>Address</th>
<th>Phone No.</th>
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**CHECK THE WEEK(S) YOU PLAN TO ATTEND & THE TIMES NEEDED**  
**WEEK** | **DATES** | **CHILD DEVELOPMENT CENTER SUMMER PROGRAM WEEKLY THEME**
---|---|---
1 | July 10-14 | ☐ Before 7:30-8:45am ($15) ☐ After 4-5:30 pm ($20) ☐ Both – Before & After ($30)
2 | July 17-21 | ☐ Before 7:30-8:45am ($15) ☐ After 4-5:30 pm ($20) ☐ Both – Before & After ($30)
3 | July 24-28 | ☐ Before 7:30-8:45am ($15) ☐ After 4-5:30 pm ($20) ☐ Both – Before & After ($30)
4 | July 31- Aug. 4 | ☐ Before 7:30-8:45am ($15) ☐ After 4-5:30 pm ($20) ☐ Both – Before & After ($30)

*All required forms and payment are due prior to the start of the child’s first week.*  
*Bring in or mail to: Jordan Child Development Center, Wor-Wic Community College, 32000 Campus Drive, Salisbury, MD 21804*
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 ________________________________________

Enrollment Date ______________________________ Hours & Days of Expected Attendance ____________________________________

Child’s Home Address __________________________________________________________________________________________________________
Street/Apt.# City State Zip Code

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

Name of Person Authorized to Pick Up Child (daily) ________________________________________________________________________________

Address ___________________________________________________________  Last    First   Relationship to Child
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 ________________________________

OCC 1214 (Revised 9/12) - Side 1 of 2 - All previous editions are obsolete.
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

OCC 1214 (Revised 9/12 ) - Side 2 of 2 - All previous editions are obsolete.
HEALTH HISTORY FORM
For Use in Drop-In Child Care Centers*

Child’s Name: _________________________________________ Birth Date: __________________________

Parent/Guardian Name: __________________________________ Relationship: ________________________

Check the correct answers to the following questions. Give a brief explanation under COMMENTS for any YES answer.

<table>
<thead>
<tr>
<th>Does the child have any of the following?</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>a) Vision problem?</td>
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<td>b) Hearing problem?</td>
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<td>c) Speech or language problem?</td>
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<td>d) Physical illness or impairment problem?</td>
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<td>e) Mental, emotional or behavioral problem?</td>
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<td>f) Developmental delay?</td>
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<td>g) Allergies?</td>
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<td>h) Other? (If YES, specify)</td>
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<tr>
<td>i) Health condition which may require care or emergency action? (If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.)</td>
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<td>j) Does the child have up-to-date immunizations?</td>
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<td>k) Is the child currently taking any medication?</td>
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This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities.

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<tr>
<th>YES</th>
<th>NO</th>
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List any areas of the program in which the child cannot fully participate. Would any limits or alterations help to meet his or her needs? Please explain briefly.

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Signature of Parent/Guardian  Date

* A parent may object when medical examination of a child conflicts with the parent’s bona fide religious belief and practice. Under such circumstances, the parent may also use this form.

OCC 1285 (Revised 7/05) · All previous editions are obsolete.