



Child Development Center

Enrollment Forms



JC Dolphins

2 Years Old

Creative Investigators

3-5 Years Old



License # 141284



Children's File Checklist

Child'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 Child Care
- ☐ Emergency Contact Form
- ☐ Health Inventory Form: Part I & II (OCC 1215), Medication Authorization (OCC 1216) Parent/Guardian
- ☐ Consent Form (Handbook, Parent's Guide to Regulated Child Care, Photo, Allergy, Communicable Disease Summary)
- ☐ USDA Food Program CACFP
- ☐ Food Program Child Care Enrollment Form
- ☐ Include copy of IEP _____ or IFSP _____

Entered by staff: _____

ProCare Windows:

- ☐ Basic Information
- ☐ Contacts
- ☐ Schedule
- ☐ Medical
- ☐ Consent forms

Comments:

Copy of the following to Teachers:

- ☐ Emergency Form
- ☐ Authorized Pickup
- ☐ Misc(Any court orders or medical information)

CHILD DEVELOPMENT CENTER REGISTRATION FORM

Student ID Number _____ - _____ - _____

Year: _____

Parents Name: _____
Last First Middle

Child(ren)'s Name: _____
Last First Middle

Telephone: _____
Home or cell Work

- ☐ Fall
- ☐ Fall I
- ☐ Fall II
- ☐ Spring
- ☐ Spring I
- ☐ Spring II
- ☐ Summer
- ☐ Summer I
- ☐ Summer II
- ☐ Update/Change
- Date: _____

2-year-old COST PER WEEK: ☐ Student (\$175 or \$42 per day) ☐ Employee (\$190) ☐ Community (\$215)

3-5-year-old COST PER WEEK: ☐ Student (\$165 or \$37 per day) ☐ Employee (\$180) ☐ Community (\$195)

Daytime Hours: Student minimum of three full days per week/ Employee and Community Full-time only

Day	Time	# of Children
2 YEAR OLDS (MONDAY – FRIDAY)		
☐ Monday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Tuesday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Wednesday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Thursday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Friday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
3 -5 YEAR OLDS (MONDAY – FRIDAY)		
☐ Monday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Tuesday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Wednesday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Thursday	7:30 – 5:00 p.m.	1 ☐ 2 ☐
☐ Friday	7:30 – 5:00 p.m.	1 ☐ 2 ☐

WITHDRAWAL POLICY:

UPON SIGNATURE, PARENTS OR GUARDIANS AGREE AND UNDERSTAND THE FOLLOWING:

Effective immediately, the Wor-Wic Community College Child Development Center administration requires a minimum of two weeks notice before withdrawing a child. If proper notice for withdrawal is not given, parents will be charged for the two weeks. Please note that if the last two weeks tuition is not paid, this charge will be attached to your college bill and grades will not be released until the bill is paid.

Parent Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

WOR-WIC

COMMUNITY COLLEGE

Application for Child Care

Child's First & Last Name _____ Birth date _____ Age _____ ☐ Male ☐ Female

Race: ☐Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐Native American ☐Other

Address _____

City _____

State _____

Zip _____

Mother/Guardian First & Last Name _____

Pager/Cell _____

Employer & Address _____

Phone (w) _____

Address (if different than child's) _____

Phone (h) _____

Email: _____

Father/Guardian First & Last Name _____

Pager/Cell _____

Employer & Address _____

Phone (w) _____

Address (if different than child's) _____

Phone (h) _____

Email: _____

Please select the age-appropriate room desired for the child listed above:

☐ 2 years old ☐ 3-5 years old

Students Only: SCHEDULE OF SESSIONS (Please indicate the sessions that are needed.)

7:30 a.m.
to
5:00 p.m.

☐ Monday/Wednesday

☐ Tuesday/Thursday

☐ Friday

Wor-Wic Community College students requesting childcare services must be registered for classes and have their schedule of classes attached in order to receive first preference, optional part time status and discounted rate.

Signature of Parent or Guardian _____ Date _____

Director Approval _____ Date _____

**CHILD CARE REGISTRATION IS CONTINGENT UPON RECEIPT
OF ALL REQUIRED COMPLETED ENROLLMENT FORMS**

See the "*Child Development Center Policies and Procedures Manual for Parents*" for all our policies

A CHILD MAY NOT START AT THE CENTER UNTIL THE DIRECTOR APPROVES THE APPLICATION.

To secure your child a registered space, a non-refundable deposit of one week tuition plus material fee is required.

CACFP Enrollment: Yes:___ No:___

BK LN SU AM Snk PM Snk Evng Snk

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (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
12/1/2023	10:00 AM - 12:00 PM, 12/1/2023
12/1/2023	1:00 PM - 3:00 PM, 12/1/2023
12/1/2023	3:30 PM - 5:30 PM, 12/1/2023
12/1/2023	6:00 PM - 8:00 PM, 12/1/2023
12/1/2023	8:30 PM - 10:30 PM, 12/1/2023
12/1/2023	11:00 PM - 1:00 AM, 12/1/2023
12/1/2023	1:30 AM - 3:30 AM, 12/1/2023
12/1/2023	4:00 AM - 6:00 AM, 12/1/2023
12/1/2023	6:30 AM - 8:30 AM, 12/1/2023
12/1/2023	9:00 AM - 11:00 AM, 12/1/2023
12/1/2023	11:30 AM - 1:30 PM, 12/1/2023
12/1/2023	2:00 PM - 4:00 PM, 12/1/2023
12/1/2023	4:30 PM - 6:30 PM, 12/1/2023
12/1/2023	7:00 PM - 9:00 PM, 12/1/2023
12/1/2023	9:30 PM - 11:30 PM, 12/1/2023
12/1/2023	12:00 AM - 2:00 AM, 12/1/2023
12/1/2023	2:30 AM - 4:30 AM, 12/1/2023
12/1/2023	5:00 AM - 7:00 AM, 12/1/2023
12/1/2023	7:30 AM - 9:30 AM, 12/1/2023
12/1/2023	10:00 AM - 12:00 PM, 12/1/2023
12/1/2023	12:30 PM - 2:30 PM, 12/1/2023
12/1/2023	3:00 PM - 5:00 PM, 12/1/2023
12/1/2023	5:30 PM - 7:30 PM, 12/1/2023
12/1/2023	8:00 PM - 10:00 PM, 12/1/2023
12/1/2023	10:30 PM - 12:30 AM, 12/1/2023
12/1/2023	1:00 AM - 3:00 AM, 12/1/2023
12/1/2023	3:30 AM - 5:30 AM, 12/1/2023
12/1/2023	6:00 AM - 8:00 AM, 12/1/2023
12/1/2023	8:30 AM - 10:30 AM, 12/1/2023
12/1/2023	11:00 AM - 1:00 PM, 12/1/2023
12/1/2023	1:30 PM - 3:30 PM, 12/1/2023
12/1/2023	4:00 PM - 6:00 PM, 12/1/2023
12/1/2023	6:30 PM - 8:30 PM, 12/1/2023
12/1/2023	9:00 PM - 11:00 PM, 12/1/2023
12/1/2023	11:30 PM - 1:30 AM, 12/1/2023
12/1/2023	2:00 AM - 4:00 AM, 12/1/2023
12/1/2023	4:30 AM - 6:30 AM, 12/1/2023
12/1/2023	7:00 PM - 9:00 PM, 12/1/2023
12/1/2023	9:30 PM - 11:30 PM, 12/1/2023
12/1/2023	12:00 AM - 2:00 AM, 12/1/2023
12/1/2023	2:30 AM - 4:30 AM, 12/1/2023
12/1/2023	5:00 AM - 7:00 AM, 12/1/2023
12/1/2023	7:30 AM - 9:30 AM, 12/1/2023
12/1/2023	10:00 AM - 12:00 PM, 12/1/2023
12/1/2023	12:30 PM - 2:30 PM, 12/1/2023
12/1/2023	3:00 PM - 5:00 PM, 12/1/2023
12/1/2023	5:30 PM - 7:30 PM, 12/1/2023
12/1/2023	8:00 PM - 10:00 PM, 12/1/2023
12/1/2023	10:30 PM - 12:30 AM, 12/1/2023
12/1/2023	1:00 AM - 3:00 AM, 12/1/2023
12/1/2023	3:30 AM - 5:30 AM, 12/1/2023
12/1/2023	6:00 AM - 8:00 AM, 12/1/2023
12/1/2023	8:30 AM - 10:30 AM, 12/1/2023
12/1/2023	11:00 AM - 1:00 PM, 12/1/2023
12/1/2023	1:30 PM - 3:30 PM, 12/1/2023
12/1/2023	4:00 PM - 6:00 PM, 12/1/2023
12/1/2023	6:30 PM - 8:30 PM, 12/1/2023
12/1/2023	9:00 PM - 11:00 PM, 12/1/2023
12/1/2023	11:30 PM - 1:30 AM, 12/1/2023
12/1/2023	2:00 AM - 4:00 AM, 12/1/2023
12/1/2023	4:30 AM - 6:30 AM, 12/1/2023
12/1/2023	7:00 PM - 9:00 PM, 12/1/2023
12/1/2023	9:30 PM - 11:30 PM, 12/1/2023
12/1/2023	12:00 AM - 2:00 AM, 12/1/2023
12/1/2023	2:30 AM - 4:30 AM, 12/1/2023
12/1/2023	5:00 AM - 7:00 AM, 12/1/2023
12/1/2023	7:30 AM - 9:30 AM, 12/1/2023
12/1/2023	10:00 AM - 12:00 PM, 12/1/2023
12/1/2023	12:30 PM - 2:30 PM, 12/1/2023
12/1/2023	3:00 PM - 5:00 PM, 12/1/2023
12/1/2023	5:30 PM - 7:30 PM, 12/1/2023
12/1/2023	8:00 PM - 10:00 PM, 12/1/2023
12/1/2023	10:30 PM - 12:30 AM, 12/1/2023
12/1/2023	1:00 AM - 3:00 AM, 12/1/2023
12/1/2023	3:30 AM - 5:30 AM, 12/1/2023
12/1/2023	6:00 AM - 8:00 AM, 12/1/2023
12/1/2023	8:30 AM - 10:30 AM, 12/1/2023
12/1/2023	11:00 AM - 1:00 PM, 12/1/2023
12/1/2023	1:30 PM - 3:30 PM

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

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

Address	Street/Apt. #	City	State	Zip Code
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Any Changes/Additional Information_____

ANNUAL UPDATES

(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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 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: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name:			Birth date:		Sex
Last First Middle			Mo / Day / Yr		M ☐ F ☐
Address:					
Number Street Apt# City State Zip					
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W:	C:	H:	
		W:	C:	H:	
Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for	
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:	
Address:	Address:	Address:	Child Care Scholarship	Dental Care:	
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:	
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	☐	☐			
Asthma or Breathing	☐	☐			
ADHD	☐	☐			
Autism Spectrum Disorder	☐	☐			
Behavioral or Emotional	☐	☐			
Birth Defect(s)	☐	☐			
Bladder	☐	☐			
Bleeding	☐	☐			
Bowels	☐	☐			
Cerebral Palsy	☐	☐			
Communication	☐	☐			
Developmental Delay	☐	☐			
Diabetes Mellitus	☐	☐			
Ears or Deafness	☐	☐			
Eyes	☐	☐			
Feeding/Special Dietary Needs	☐	☐			
Head Injury	☐	☐			
Heart	☐	☐			
Hospitalization (When, Where, Why)	☐	☐			
Lead Poisoning/Exposure	☐	☐			
Life Threatening/Anaphylactic Reactions	☐	☐			
Limits on Physical Activity	☐	☐			
Meningitis	☐	☐			
Mobility-Assistive Devices if any	☐	☐			
Prematurity	☐	☐			
Seizures	☐	☐			
Sensory Impairment	☐	☐			
Sickle Cell Disease	☐	☐			
Speech/Language	☐	☐			
Surgery	☐	☐			
Vision	☐	☐			
Other	☐	☐			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition? ☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.					
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) ☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
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.					
Printed Name and Signature of Parent/Guardian					Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Health Care Provider

Child's Name: _____ Last First Middle				Birth Date: _____ Month / Day / Year		Sex M ☐ F ☐	
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? ☐ No ☐ Yes, describe: _____							
2. Does the child receive care from a Health Care Specialist/Consultant? ☐ No ☐ Yes, describe: _____							
3. 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: _____							
4. Health Assessment Findings							
Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			
REMARKS: (Please explain any abnormal findings.) 							
5. Measurements		Date		Results/Remarks			
Tuberculosis Screening/Test, if indicated							
Blood Pressure							
Height							
Weight							
BMI % tile							
Developmental Screening							
6. 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). https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms							
7. Should there be any restriction of physical activity in child care? ☐ No ☐ Yes, specify nature and duration of restriction: _____							
8. Are there any dietary restrictions? ☐ No ☐ Yes, specify nature and duration of restriction: _____							
9. RECORD OF IMMUNIZATIONS – MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)							
10. RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620) Under Maryland law, all children younger than 6 years old who are enrolled in child care 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.							

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1.	_____ Name	_____ Title	Clinic/Office Name, Address, Phone
	_____ Signature	_____ Date	
2.	_____ Name	_____ Title	
	_____ Signature	_____ Date	

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

- Yes ☐ No ☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes ☐ No ☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes ☐ No ☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes ☐ No ☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes ☐ No ☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes ☐ No ☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes ☐ No ☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

Parent/Guardian Signature

Date

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

Frequently Asked Questions

1. Who should be tested for lead?

All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. What is the blood lead reference value, and how is it interpreted?

Maryland follows the [CDC blood lead reference value](#), which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?

Yes, if a capillary test shows a blood lead level of ≥ 3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See [Table 1](#) (CDC) for the recommended schedule.

4. What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?

Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (<https://www.cdc.gov/ncet/lead/advisory/acclpp/actions-blls.htm>).

5. What programs or resources are available to families with a child with lead exposure?

Maryland and local jurisdictions have programs for families with a child exposed to lead:

- Maryland Home Visiting Services for Children with Lead Poisoning
- Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: <https://health.maryland.gov/phhp/OEHFP/EH/Pages/Lead.aspx>.

Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention: <https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx>

Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.

Phone: (610) 519-3478 or Toll Free: (833) 362-2243

Website: <https://www1.villanova.edu/university/nursing/macche.html>

CHILD'S NAME _____													
				LAST				FIRST				MI	
SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____													
COUNTY _____				SCHOOL _____				GRADE _____					
PARENT NAME _____										PHONE NO. _____			
OR GUARDIAN ADDRESS _____										CITY _____ ZIP _____			

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	_____	DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr _____ _____ _____	Tdap Mo/Day/Yr _____ _____ _____	MenB Mo/Day/Yr _____ _____ _____	Other Mo/Day/Yr _____ _____ _____	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4								
5	DOSE #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

Clinic / Office Name

Office Address/ Phone Number

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication.

Signed: _____ Date _____

 Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH 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 MDH COMAR 10.06.04.03 are available at www.health.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.health.maryland.gov. (Choose Immunization in the A-Z Index)

**Maryland State Department of Education
Office of Child Care
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.
Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's
Picture Here
(optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: ____/____/____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: ____/____/____ to ____/____/____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions: _____

Known Food or Drug Allergies: ☐ Yes ☐ No If yes, please explain: _____

For School Age children only: The child may self-carry this medication: ☐ Yes ☐ No

The child may self-administer this medication: ☐ Yes ☐ No

PRESCRIBER'S NAME/TITLE

Place Stamp Here (Optional)

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** ☐ Yes ☐ No

PARENT/GUARDIAN SIGNATURE

DATE (mm/dd/yyyy)

INDIVIDUALS AUTHORIZED TO PICK UP
MEDICATION

CELL PHONE #

HOME PHONE #

WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:	1. Medication named above was received. Expiration date _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR.	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated.	☐ Yes ☐ No ☐ N/A
	4. OCC 1215 Health Inventory updated.	☐ Yes ☐ No ☐ N/A
	5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.	☐ Yes ☐ No ☐ N/A
	6. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)

**Maryland State Department of Education
Office of Child Care**

MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				Date of Birth:	
Medication Name:				Dosage:	
Route:				Time to Administer:	
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

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 or request a copy from the center associate. 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. I am aware that the web address for Guide to Regulated Child Care Brochure is available in the CDC handbook and a copy may be given to me upon request.

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

Infant and Toddler Brochure

I am aware that the web address for [Maryland Infant and Toddlers Program Brochure](#) is available in the CDC handbook, and a copy may be given to me upon request.

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.

Signature of Parent/Guardian

Date:

Date Withdrawn: _____

Maryland State Department of Education
Office of School and Community Nutrition Programs
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, age, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home

1. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	Hours from: _____ to _____	Check (✓) the days your child normally attends: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Sunday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ Lunch ☐ Supper ☐ AM Snack ☐ PM Snack ☐ Evening Snack

2. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	Hours from: _____ to _____	Check (✓) the days your child normally attends: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Sunday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ Lunch ☐ Supper ☐ AM Snack ☐ PM Snack ☐ Evening Snack

3. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	Hours from: _____ to _____	Check (✓) the days your child normally attends: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Sunday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ Lunch ☐ Supper ☐ AM Snack ☐ PM Snack ☐ Evening Snack

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____



CHILD CARE PAYMENT POLICIES

Weekly payments are due on Monday mornings.

If payment is not made on Monday, then a \$25 late fee is added on top of the tuition fee for that week. A weekly late fee will be added until the balance is paid in full. If the CCS Voucher doesn't fund the entire tuition amount, then the out of pocket co-pay is due weekly on Mondays and is subject to late fees.

If the balance is more than 30 days past due, then the college has the right to dismiss your child and the child will lose their spot in class. The outstanding tuition payments are still due to the college and you will be set up on a payment plan.

Those who are awaiting CCS Voucher funding must pay 50% tuition weekly until the CCS approval and vouchers are received. Once the college has received the CCS payment, any overpayment will be reimbursed or additional payments due will be set up on a payment plan.

Those with a current outstanding balance due beyond the weekly late fee will be contacted by the college's business office to discuss a payment plan.

The semester material fee is due the first week of the fall and spring semesters, or the first week for children who enroll mid-semester.

There are no discounts or refunds for absent days. The weekly tuition must be paid regardless of the child's attendance.

The Center closes at 5:00pm. Children must be picked up by 5:00pm. A late fee of \$10 per 5 minutes will be charged and must be paid that week or the child cannot return. More than three late pickups per month may result in the child losing their spot in class.

Parents are responsible for payment during the college's planned and unplanned closings including snow days and the following holidays: MLK Day, Memorial Day, Juneteenth, Fourth of July, Labor Day and Thanksgiving break. Parents are not charged for the college's holiday break in December.

Parent Status	Weekly Tuition	Daily Tuition	Semester Material Fee
Current Wor-Wic Students	\$165.00 per week (3-4 year olds) \$175.00 per week (2 year olds)	\$37.00 (3-4 year olds) \$42.00 (2 year olds)	\$40.00
Wor-Wic Employees	\$180.00 per week (3-4 year olds) \$190.00 per week (2 year olds)	full-time only	\$40.00
Community Members	\$195.00 per week (3-4 year olds) \$215.00 per week (2 year olds)	full-time only	\$40.00