

Child Development Center

Enrollment Forms



JC Dolphins

2-3 Years Old

Creative Investigators

4-5 Years Old





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
- Authorization Form
- Consent Form (Handbook, Parent's Guide to Regulated Child Care, Photo, Allergy, Communicable Disease Summary)
- All About My Family
- USDA Food Program CACFP
- Food Program Child Care Enrollment Form
- Tour of Facility
- Brigance Assessment
- Include copy of IEP _____ or IFSP _____

Entered by staff: _____

- ProCare Windows:
 - Basic Information
 - Contacts
 - Schedule
 - Medical
 - Consent forms
 - Photo of all contacts

Comments:

Copy of the following to Teachers:

- All about me
- Emergency Form
- Authorized Pickup
- Misc(Any court orders or medical information)



CHILD DEVELOPMENT CENTER REGISTRATION FORM FOR CURRENTLY ENROLLED CHILDREN

Student ID Number _____ - _____ - _____

Year: _____

Parent Name: _____
Last
First
Middle

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

Child(ren)'s Name: _____

Last
First
Middle

Telephone: _____
Home or cell
Work

COST PER BLOCK: Student (\$17) Employee (\$19) Community (\$33 per day)

Daytime Hours: Minimum of three full days per week/ Community Full-time only

Day	Number of Blocks	Time	# of Children	# of weeks (circle)	Blocks (x) Children
2 -3 YEAR OLDS (MONDAY –FRIDAY)					
<input type="checkbox"/> Monday & Wednesday	2	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Monday & Wednesday	2	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Tuesday & Thursday	2	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Tuesday & Thursday	2	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Friday	1	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Friday	1	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
4 -5 YEAR OLDS (MONDAY – FRIDAY)					
<input type="checkbox"/> Monday & Wednesday	2	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Monday & Wednesday	2	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Tuesday & Thursday	2	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Tuesday & Thursday	2	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Friday	1	7:30 – 12:30 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	
<input type="checkbox"/> Friday	1	12:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 8 14 16	

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, then parents will be charged for the two weeks. Please note that if the last two weeks tuition is not paid, then 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: _____



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:

2-3 years old (day) 4-5 years old (day)

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

MORNING	7:30 a.m. to 12:30 p.m.	<input type="checkbox"/> Monday/Wednesday	<input type="checkbox"/> Tuesday/Thursday	<input type="checkbox"/> Friday
AFTERNOON	12:30 p.m. to 5:00 p.m.	<input type="checkbox"/> Monday/Wednesday	<input type="checkbox"/> Tuesday/Thursday	<input type="checkbox"/> 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.

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.

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

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:
http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

Evidence of Blood-Lead Testing for children living in designated at risk areas. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at <http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name:			Birth date:			Sex	
_____ Last First Middle			_____ Mo / Day / Yr			M <input type="checkbox"/> F <input type="checkbox"/>	
Address:							
_____ Number Street		_____ Apt# City		_____ State Zip			
Parent/Guardian Name(s)		Relationship		Phone Number(s)			
				W: _____		C: _____	
				W: _____		C: _____	
Your Child's Routine Medical Care Provider				Your Child's Routine Dental Care Provider		Last Time Child Seen for Physical Exam:	
Name: _____				Name: _____		Dental Care: _____	
Address: _____				Address: _____		Any Specialist: _____	
Phone # _____				Phone _____			
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.							
	Yes	No	Comments (required for any Yes answer)				
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>					
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>					
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>					
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>					
Bladder	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>					
Bowels	<input type="checkbox"/>	<input type="checkbox"/>					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>					
Coughing	<input type="checkbox"/>	<input type="checkbox"/>					
Communication	<input type="checkbox"/>	<input type="checkbox"/>					
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Feeding	<input type="checkbox"/>	<input type="checkbox"/>					
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>					
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>					
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>					
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>					
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>					
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>					
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>					
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>					
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____							
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.							
Signature of Parent/Guardian _____						Date _____	

PART II - CHILD HEALTH ASSESSMENT
To be completed ONLY by Physician/Nurse Practitioner

Child's Name:	Birth Date:	Sex
Last First Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

1. Does the child named above have a diagnosed medical condition?
 No Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
 No Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/ or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmm_896_-_february_2014.pdf)

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

5. Is the child on medication?
 No Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?
 No Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1 Test#2	Test # 1 Test #2

_____ **has had a complete physical examination and any concerns have been noted above.**
(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 STREET ADDRESS (with Apartment Number) CITY STATE ZIP
 SEX: Male Female BIRTHDATE _____ / _____ / _____ PHONE _____
 PARENT OR GUARDIAN _____ / _____ / _____
 LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? YES NO
 Has this child ever lived in one of the areas listed on the back of this form? YES NO
 Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? YES NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: Health Care Provider/Designee OR School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: YES NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. 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.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

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

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

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

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type													
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

- Signature _____ Title _____ Date _____
(Medical provider, local health department official, school official, or child care provider only)
- Signature _____ Title _____ Date _____
- Signature _____ Title _____ Date _____

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 DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.dhmv.maryland.gov. (Choose Immunization in the A-Z Index)

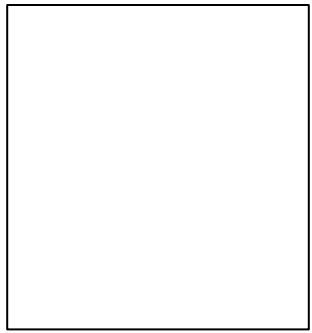
Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at www.dhmv.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.



Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

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

If PRN, for what symptoms: _____

Possible side effects & special instructions: _____

Medication shall be administered from: _____ to _____

Known Food or Drug: Allergies? Yes No If Yes, please explain _____
Month / Day / Year Month / Day / Year (not to exceed 1 year)

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

Telephone: _____ FAX: _____

Address: _____

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



This space may 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 attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

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 Health Care Plan Received: YES NO

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



PARENT/GUARDIAN AUTHORIZATION

The following are AUTHORIZED people who MAY sign for this child (a photo is needed for each person listed):

1. Name _____ Phone # _____
Address _____
City _____ State _____ Zip _____
Name _____ Phone # _____
2. Address _____
City _____ State _____ Zip _____
Name _____ Phone # _____
3. Address _____
City _____ State _____ Zip _____
Name _____ Phone # _____
4. Address _____
City _____ State _____ Zip _____

The following are UN-AUTHORIZED people and MAY NOT sign for this child:

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 or 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. 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

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 affect any lunches or snack I as a parent or guardian provide. If I have any questions about a product I am providing I will seek the help of the Center Staff.

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

ALL ABOUT MY FAMILY

Instructions

The Wor-Wic Community College Child Development Center is devoted to providing your child with the best possible growing experience. A major component of a child's growth is learning to recognize and accept similarities and differences amongst their peers. This brief survey helps us to understand the family values and traditions important to each child. We want to ensure that your child is being cared for in an environment that is sensitive to both the familial and cultural traditions being taught at home.

** Please note that the information contained herein is for CONFIDENTIAL USE ONLY and that your participation in this survey is voluntary.*

THE PEOPLE IN MY FAMILY ARE: We'd like to know who is important to your child. Please indicate household members (parents, step-parents, significant others, grandparents, aunts, uncles, siblings, cousins, pets, etc.) or others that play a vital role in your child's life.

WHEN WE'RE AT HOME WE SPEAK: Indicate the primary language(s) spoken at home or with other family members. Also include any identification terms that may be necessary to understand you child's wants and needs. For example, please let us know if your child has a special name/word for their blanket, stuffed toy, cup, bathroom, naptime, etc. to ease communication.

SOME OF OUR MOST IMPORTANT FAMILY VALUES ARE: Each family has a set of core values that everyone is expected to live by. These values can be things like love, honesty, fairness, faith, etc. List those that are of the highest importance in your family.

WHEN WE ARE TOGETHER WE LIKE TO: What does your family like to do when they are spending time together? Some examples are: playing soccer, going to the beach, family game night, bowling, reading, painting, fishing, etc.

WE LIKE TO CELEBRATE: What holidays or seasons does your family celebrate? What do you do to celebrate them?

SOME OF OUR SPECIAL FAMILY TRADITIONS ARE: Does your family always go to Grandma's house on Sundays for dinner? Do you take a trip to Florida every winter? Do you sing a special birthday song or read the same book every night before bed? Please share any traditions that may be important to your child.

Again, thank you for completing this survey. The answers you provided will help your child's teacher to better understand your child and the things in life that are important to them. If you have any questions about this survey, or any other matter, please do not hesitate to contact the Child Development Center staff.

ALL ABOUT MY FAMILY

Child's first name or nickname: _____

The information contained herein is for CONFIDENTIAL USE ONLY.

THE PEOPLE IN MY FAMILY ARE

WHEN WE'RE AT HOME, WE SPEAK

SOME OF OUR IMPORTANT FAMILY VALUES ARE

WHEN WE ARE TOGETHER, WE LIKE TO

WE LIKE TO CELEBRATE

SOME OF OUR SPECIAL FAMILY TRADITIONS ARE

Is this your child's first time in school, if no than what school did they attend?

**Child Care Centers
Meal Benefit Application
July 1, 2023 - June 30, 2024**

Complete one application per household. For more information, read **Instructions for Completing** or call **[410-334-2962]**

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 Do any Household Members (including you) currently participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)? Circle One: **Yes** **No**

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number:

Step 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:

Check if No SSN:

Step 4 Contact Information and Adult Signature

I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

Hispanic or Latino
 Not Hispanic or Latino

Race (Check one or more):

American Indian or Alaskan Native Black or African American White
 Asian Native Hawaiian or Other Pacific Islander

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

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

Total Income (Children and Adults): \$ _____ Weekly Every 2 Weeks Twice a Month Monthly Yearly

Eligibility: Free Categorically Eligible Reduced Paid

Determining Official's Signature: _____ 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 <small>(For example 7:30 AM – 5 PM)</small>	Hours from: _____ to _____	Check (✓) the days your child normally attends: <input type="checkbox"/> Monday <input type="checkbox"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	Check (✓) the meals that your child will receive while in care: <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack

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

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

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____



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,

**Peanut
Free Zone!**

Wor-Wic Child Development Center Staff

