



**WOR-WIC**  
COMMUNITY COLLEGE



# Camp Jordan

Ages 5 to 8

Register by May 29, 2024

**\$195 per week includes:**  
Breakfast and Snack, Swimming, Field Trips  
and Specialty Activities  
Monday-Friday, 7:30 a.m. - 5 p.m.

\$30  
deposit fee  
(non-refundable)  
due with enrollment  
application.  
Must register for  
a full week.



**Activities**

- Specialty Activities**
- Guided Computer Use
  - Swimming
  - Arts and Crafts
  - Science Experiments
  - Athletics and Games
  - Electronics, Gizmos and Gadgets Day

32000 Campus Dr.  
Salisbury MD 21804  
worwic.edu



**Trips**

- Field Trips**
- Regal Cinemas
  - Frontier Town –
  - Water Park
  - Ocean Resorts Golf Club
  - Salisbury Airport



**Visitors**

- Visitors**
- K-9 Ambassador Club
  - 4-H Bike Rodeo
  - NASA Wallops Island
  - Ward Museum
  - UMES-Nutrition Program

**8 Weeks of Fun!**

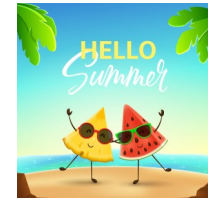
- Week 1 (6/24-28)
- Week 2 (7/1-5)
- Week 3 (7/8-12)
- Week 4 (7/15-19)
- Week 5 (7/22-26)
- Week 6 (7/29-8/2)
- Week 7 (8/5-9)
- Week 8 (8/12-16)

- Welcome Week
- Eric Carle Week
- Lego Mania
- Lets Go to Disney
- Elements of Art
- Ready, Set and Game
- Adventures of Oceanography
- Anything Goes



# Camp Jordan

Monday - Friday 7:30 a.m. - 5:00 p.m.  
Ages 5—8 years old



7:30 - 8:30	Arrival: Independent Stations
8:30 - 8:40	Clean-up/Bathroom
8:40 - 9:00	Breakfast
9:00 - 9:30	Morning Meeting (Current Event Topics, Message Board, Word of the Day)
9:30 - 10:30	Group Activity: Arts & Crafts
10:30 - 11:30	Outside Activities/Group Games
11:30 - 12:00	LUNCH
12:00 - 1:00	Fitness Activity: Gym, yoga, jump rope, etc.
1:00 - 1:30	Enrichment Activity Time (Math Facts, Geography, Social Studies)
1:30 - 2:30	Independent Stations/Open Center/Projects
2:30 - 3:00	Enrichment Activity (Science Exploration)
3:00 - 3:15	PM Snack
3:15 - 3:45	Independent Reading
3:45 - 4:30	Dance Activities
4:30 - 5:00	Large Motor/Outside Activities
5:00	Wrap-up/Dismissal

- Activities are subject to change due to scheduled field trips or visitors.



**WOR-WIC**  
COMMUNITY COLLEGE



# Camp Jordan



Enrollment Forms

5-8 Year Old Summer Camp  
Program





## Camp Jordan Checklist

Camper's Name: \_\_\_\_\_

Please place forms in order of list:

Enrollment Date: \_\_\_\_\_

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

Entered by staff: \_\_\_\_\_

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

Fees Paid:

- Deposit Fee \$ 30.00 (non-refundable)
- \$\_\_\_\_\_ First week deposit

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

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Wor-Wic Camp Jordan

REGISTER YOUR 5-8 YEAR OLD FOR EXCITING PROGRAMS  
TODAY THRU MAY 3, 2024!!!

## SUMMER PROGRAM DATES & TIMES

**June 24- August 16, 2024**  
**Monday-Friday, 7:30 a.m. - 5:00 p.m.**  
**Weekly Full-time Sessions!**



Child's Name \_\_\_\_\_

Date \_\_\_\_\_

WEEKLY CAMP FEES	CHECK THE WEEKS ATTENDING	SESSION	DATES	THEME
\$195.00 Per Week	<input type="checkbox"/>	Week 1	June 24-28	Welcome Week
\$195.00 Per Week	<input type="checkbox"/>	Week 2	July 1-5*	Eric Carle Week
\$195.00 Per Week	<input type="checkbox"/>	Week 3	July 8-12	LEGO Mania
\$195.00 Per Week	<input type="checkbox"/>	Week 4	July 15-19	Let's Go to Disney
\$195.00 Per Week	<input type="checkbox"/>	Week 5	July 22-26	Elements of Art
\$195.00 Per Week	<input type="checkbox"/>	Week 6	July 29- Aug 2	Ready, Set and Game!
\$195.00 Per Week	<input type="checkbox"/>	Week 7	August 5-9	Adventures of Oceanography
\$195.00 Per Week	<input type="checkbox"/>	Week 8	August 12-16	Anything Goes!

**Deposit Fee: \$ 30.00 (non-refundable) due with enrollment application**

**WOR-WIC**  
COMMUNITY COLLEGE



Camp Jordan
Application for Summer Program



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 Phone (w)

Address (if different than child's)

Phone (h)

Email:

Father/Guardian First & Last Name Pager/Cell

Employer Phone (w)

Address (if different than child's)

Phone (h)

Email:

Please select the appropriate status:
Wor-Wic Community College Student
Wor-Wic Community College Employee
Community Member

Name of School Child(ren) attend:

Phone Number of School:

Camp Jordan offers weekly full time sessions.
You can sign up for one or more weeks, or the entire summer!
June 24 to August 16, 2024
Application deadline and first week deposit are due by May 3, 2024
Call for questions: 410-334-2962
A CAMPER MAY NOT START AT THE CENTER UNTIL ALL FORMS ARE SUBMITTED AND FEES ARE PAID IN FULL.



**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



**Camp Jordan  
PARENT/GUARDIAN AUTHORIZATION**

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

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
1. 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 camper:

1. \_\_\_\_\_  
2. \_\_\_\_\_

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

The person described herein has my permission to participate and engage in child care activities.  
I understand the fee structure for Wor-Wic Community College child care programs, and will pay according to the prescribed payment plan unless prior written agreement has been made with the cashier's office.  
I give my permission to Wor-Wic Community College, without obligation to me, to use any photographs, film footage, tape recordings which may include my child's image or voice for purposes or promoting or interpreting Wor-Wic Community College Child Care programs.  
The terms herein shall serve as the parent/guardian authorization release, and assumption 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

# 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](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](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**

<b>Child's Name:</b>			<b>Birth date:</b>			<b>Sex</b>	
_____ Last                      First                      Middle			_____ Mo / Day / Yr			M <input type="checkbox"/> F <input type="checkbox"/>	
<b>Address:</b>							
_____ Number      Street		_____ Apt#      City		_____ State      Zip			
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>		<b>Phone Number(s)</b>			
				W: _____		C: _____	
				W: _____		C: _____	
<b>Your Child's Routine Medical Care Provider</b>				<b>Your Child's Routine Dental Care Provider</b>		<b>Last Time Child Seen for Physical Exam:</b>	
Name: _____				Name: _____		Dental Care: _____	
Address: _____				Address: _____		Any Specialist: _____	
Phone # _____				Phone _____			
<b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.							
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>				
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"/>					
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b>							
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Counseling etc.)							
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
<b>Does your child require any special procedures?</b> (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.							
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>							
Signature of Parent/Guardian _____						Date _____	

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

<b>Child's Name:</b>	<b>Birth Date:</b>	<b>Sex</b>
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](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

1. \_\_\_\_\_  
 Signature Title Date  
 (Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

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

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

**MEDICAL CONTRAINDICATION:**

**Please check the appropriate box to describe the medical contraindication.**

This is a:  Permanent condition OR  Temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

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

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
 Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## How To Use This Form

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

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

### Notes:

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

## Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

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

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

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

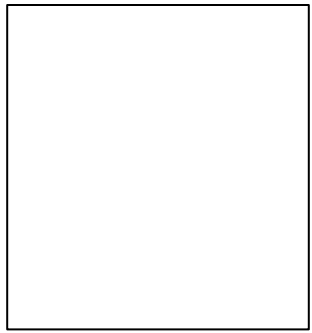
Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline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



# Child Development Center Camp Jordan

## Consent Form Parent Handbook, Photo Release, Allergy Notice, and Communicable Disease Summary

### Handbook

Child Development Center Handbook is located at [www.worwic.edu](http://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

**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.

<b>Name of Child Care Center/Home</b>

<b>1. Child's Name</b>		<b>Child's Date of Birth (MM/DD/YYYY)</b>	
<b>Times Child Normally in Care</b> <small>(For example 7:30 AM – 5 PM)</small>	<b>Hours from:</b>  _____ to _____	<b>Check (✓) the days your child normally attends:</b>  <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	<b>Check (✓) the meals that your child will receive while in care:</b>  <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

<b>2. Child's Name</b>		<b>Child's Date of Birth (MM/DD/YYYY)</b>	
<b>Times Child Normally in Care</b> <small>(For example 7:30 AM – 5 PM)</small>	<b>Hours from:</b>  _____ to _____	<b>Check (✓) the days your child normally attends:</b>  <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	<b>Check (✓) the meals that your child will receive while in care:</b>  <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

<b>3. Child's Name</b>		<b>Child's Date of Birth (MM/DD/YYYY)</b>	
<b>Times Child Normally in Care</b> <small>(For example 7:30 AM – 5 PM)</small>	<b>Hours from:</b>  _____ to _____	<b>Check (✓) the days your child normally attends:</b>  <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	<b>Check (✓) the meals that your child will receive while in care:</b>  <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

