AGAPE' EARLY CHILDHOOD LEARNING, DEVELOPMENT AND FAMILY LIFE CENTER

4318 Rhode Island Avenue P.O. Box 64
Brentwood MD, 20722
(301) 927 - 4674

WELCOME BACK! Thank you in advance for your patience and cooperation with us as we ALL worked our way through this past school year. Due to the sharp increase in prices everywhere, we have also had to increase our prices. Attached is the new application for the 2024-2025 school year. Changes are as follows:

1. The registration/application fee is $100 per student
2. Tuition prices are increasing for this school year. They are as follows:
    - **Infant Care:** $250 Per student
    - **Non-Potty Trained:** $200 Per Student
    - **Potty Trained:** $190 Per Student
    - **After Care Only:** $100 Per Student
3. **PLEASE NOTE:** We are **NO LONGER** offering Before Care Services to include taking students to elementary schools in the mornings. We will only do pick-up in the afternoons.
4. We will continue to do everything possible to keep all of us safe (sanitizing and disinfecting the Center). The training that we are receiving from the Child Care Administration is guiding us as to how to help keep each person safe.
5. Parents will continue to **CHECK-IN** and **CHECK -OUT** your child at the front door. You must sign your child **IN** for the day and **OUT** in the afternoons. You will leave your child at the front door with our staff for **CHECK-IN,** and we will bring your child from their classroom up to you in the afternoon.
6. We will check your child **IN** and **OUT** on the Brightwheel app each day. Please make sure you download the app to your phone so that you can communicate with your child's Teachers, and we can communicate with you if needed throughout the day.
7. We ask that **ALL** children be picked up by **5:30pm** so that we can have time to thoroughly clean and sanitize the whole Center in preparation for the next school day.
8. Face masks are no longer required at the time for students ages 2 and over, however, we do that the right to reinforce masks if the situation warrants.
9. Rules and regulations will change and could be rearranged by the administration to ensure the safety of all. Thank you for your patience as we work through this.
10. All payments will be made through Brightwheel. We will **NOT** be accepting any more cash payments. All payments must be through credit or debit.
11. All applications **MUST** be filled out on the website (www.agapeearly.com) and submitted to the Center at agapeearly@gmail.com. Please ensure the application is completed in its entirety before submitting.

12. **All students in the Preschool Program (ages 2-5) are <u>required</u> to be in uniform <u>every day</u>.** Please keep 2 extra sets of clothing (underwear, socks, shirt, and pants) in case of accidents.
    - **Girls:** Yellow Shirt, Navy-Blue Bottoms (pants, dress, or skirt)
    - **Boys:** Yellow Shirt and Navy-Blue Pants

    Uniforms can be purchased at "Kids for Less"
13. Class books are **required and MUST** be purchased at time of enrollment.
14. **School begins MONDAY AUGUST 26, 2024, at 6:30AM.**

If you have any questions, please feel free to contact us at (301) 927-4674. Welcome back and thank you for choosing Agape'!

Bishop Sybil Davis-Williams, Senior Director
Mrs. Sonya Johnson, Director
Mrs. Joflet Selvarajasingham, Associate Director

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2024 – 2025 SCHOOL YEAR

Fall Tuition 2024 – 2025

Application & Registration Fee (Due Every September)	$100

TUITIONS	
INFANT CARE	$250 Per Week
NON- POTTY TRAINED	$200 Per Week (Ages 2 yrs old)
POTTY TRAINED	$190 Per Week
AFTER CARE	$100 Per Week *Includes transportation from Mt. Rainer and Thomas Stone Elementary Schools to Center*

BOOK FEES *Each student works out of his/her own books for the whole school year. The sheets are worked in and sent home for parent review*	
BUMBLE BEES (2/3 YRS OLD)	$65 (3 Books)
DOLPHINS (3/4 YRS OLD)	$87 (4 Books)
EAGLES (4/5 YTS OLD)	$158 (8 Books)

SCHOOL SUPPLIES FOR FALL 2024-2025

- **5 - Yellow uniform Shirts**
- **3 - Navy Blue Uniform Pants (boys or girls)**
- **3 - Navy Blue Uniform Skirts (girls)**
- **Backpack**
- **1 - Pencil Box (Labeled with your child's name)**
- **2 - Pocket Portfolio Folders**
- **1 – Glue**
- **1 – Large Box of Crayons**
- **1 – Pair of Children Scissors**
- **1 – Box of Crayola Washable Markers**
- **2 – Extra sets of Clothing (Shirt, pants, socks, underwear- Labeled with your child's name)**
- **4 – Boxes of Tissue (to be shared with class)**
- **4 – Packs of Baby Wipes (to be shared with class)**
- **4 – Bottles of Antibacterial Hand Soap (to be shared with class)**
- **4 – Rolls of Paper towels (to be shared with class)**

Thank you for your support. We welcome fundraiser ideas and tax-deductible monetary donations to help with the support of our Center. If you work for a company that is interested in sponsoring our Child Care Center, please contact Mrs. Sonya Johnson at 301-927-4674. Thank you for your cooperation in these matters.

A Great Atmosphere and Place to Educate your children

Updated July 29, 2024

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APPLICATION FOR ADMISSION 2024 -2025 (PLEASE PRINT OR TYPE)

Application Date: ____________________
Date to Begin: ____________________

CHILDS INFORMATION

Childs Name:	Date of Birth:	
Name Used at Home:	Present Age:	Sex: ☐M ☐ F
Address:		
Phone Number (Home):	Phone Number (Cell):	
Email Address:		

FAMILY INFORMATION

Fathers Name:	Mothers Name:
SSN:	SSN:
Occupation:	Occupation:
Work Address:	Work Address:
Phone Number:	Phone Number:

Is the Child Adopted? ☐Y ☐ N	If yes, at what age
Stepparent? ☐Y ☐ N	If Yes, Which parent? ☐Stepmom ☐Stepdad
Death of one Parent? ☐Y ☐ N	If Yes, Which parent? ☐Mom ☐Dad
Divorced?	☐Y ☐ N
Names and Ages of other Children:	
Other persons living in the home?	☐Y ☐ N

Previous programs and/or Daycare centers attended? ☐ N/A	
Center Name:	Center Phone Number:
Center Name:	Center Phone Number:
Reason for Leaving:	

Religious Affiliation:	

SOCIAL & PHYSICAL GROWTH... IS YOUR CHILD (CHECK ALL THAT APPLY)			
Right-Handed? ☐	Left-Handed? ☐	Well-Coordinated? ☐	Clumsy? ☐
Good with Hands? ☐	Impulsive? ☐	Shy? ☐	Excitable? ☐
Restless? ☐	Happy? ☐	Domineering? ☐	Handicapped? ☐
Hypertensive? ☐	On Medication? ☐	If yes what type of medication?	

DOES YOUR CHILD…

Have falling spells?	☐Y	☐N
Exhibit Daredevil Behavior?	☐Y	☐N
Have unusual Fears?	☐Y	☐N
Talk Well?	☐Y	☐N
Have a good attitude about his/herself?	☐Y	☐N
Get along well with other children?	☐Y	☐N
Have special Needs?	☐Y	☐N
If yes, are your willing to share a copy of their IEP/IFSP?	☐Y	☐N

Are there any other characteristics that your child exhibits that we should know about? Please explain below:

Any food allergies? ☐Y ☐ N	If yes, please list:

Child T-Shirt Size?	

MORNING DROP OFF TIME EVERYDAY (PLEASE SELECT ONE)	
☐6:30AM – 6:45AM	☐7:45AM – 8:00AM
☐6:45 AM – 7:00AM	☐8:00AM – 8:15AM
☐7:00AM – 7:15AM	☐8:15AM – 8:30 AM
☐7:15AM – 7:30AM	☐8:30AM – 8:45AM
☐7:30AM – 7:45AM	☐8:45AM – 9:00AM

AFTERNOON PICKUP TIME EVERYDAY (PLEASE SELECT ONE)	
☐3:30PM – 3:45PM	☐4:30PM – 4:45PM
☐3:45PM – 4:00PM	☐4:45PM – 5:00PM
☐4:00PM – 4:15PM	☐5:00PM – 5:15PM
☐4:15PM – 4:30PM	☐5:15PM – 5:30PM

ALL STUDENTS SHOULD BE PICKED UP BY 5:30PM, SO THE STAFF CAN DISINFECT THE ENTIRE CENTER FOR THE NEXT DAY

OFFICE USE ONLY

Start Date:		
Child Class:		
Orientation Date:		
Registration Paid:	**$**	**Date Paid:**
Book Fees:	**$**	**Date Paid:**
Books Received Date:		**Staff Initials:**
T-Shirt Received Date:		**Staff Initials:**
Yearbook Received:		**Staff Initials:**

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APPLICATION FOR ADMISSION 2024 -2025 (PLEASE PRINT OR TYPE)
(*INFANT ADDENDUM ONLY*)

Childs Name:	
Date of Birth:	

*What Are you currently feeding your child?	Infant Formula☐	Breast Milk ☐	Other ☐
*How often does your child eat per day?			
SOCIAL AND PHYSICAL GROWTH			
*Does your child sleep in a room alone?	☐Y ☐N		
*Does your child sleep in a crib?	☐Y ☐N		
DEVELOPMENT HISTORY OF CHILD			
At age which child:	Crept up on hands and knees?		
	Sat up Alone?		
	Walked Alone?		
	Begin to name simple objects?		
	Slept through the night?		
	Repeat short sentences?		
	Begin toilet training?		

Word child uses for:	Urination:	Bowel Movements:	Usual time for Bowel Movement:
Does Child Dress themselves? ☐Y ☐N	Undress themselves? ☐Y ☐N		
What time does your child usually eat?	Breakfast:	Lunch:	Snack:
Is your family vegetarian? ☐Y ☐N	Other dietary restrictions?		

HEATH HISTORY OF CHILD	
What past illnesses has your child had? (please include at what age)	
Chicken Pox: ☐ N/A	Diabetes: ☐ N/A
Measles: ☐ N/A	Scarlet Fever: ☐ N/A
Mumps: ☐ N/A	Other:
Does your child have frequent colds and/or ear infections? ☐Y ☐N	If yes, please explain:
Any Allergies? ☐Y ☐N	If yes, how does it usually manifest itself? ☐Asthma ☐Hay Fever ☐Hives ☐ Other

Who has cared for the child other that his/her parents?
Has your child had experiences in playing with other children? ☐Y ☐N
By nature, is your child… ☐Friendly ☐Withdrawn ☐Aggressive ☐Shy
What makes your child upset?
How does your child show his/her feelings?
What do you find is the best way of handling your child?
Who does most of the disciplining?
How do you comfort your child?
Is your child frightened by any of the following? ☐Animals ☐Dark ☐Loud Noises ☐Storms
Are there any other characteristics that your child exhibits that we should know about? If so, please explain:
Additional Comments (in what way can we help your child?)

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PARENT & CENTER AGREEMENT

Agape' Early Childhood Learning, Development Center aims to enrich the life of each child by encouraging and planning for the mental, social, emotional, physical, and spiritual development involved with the care of:

Childs Name:	

The following terms are understood and agreed between Agape' Early Childhood Learning, Development Center and Parent or Guardian.

Parent or Guardians Name:	

The Center Agrees:

We are Closed Saturday and Sunday and the following holidays and "in service" training days:

New Years Eve	Memorial Day	Veterans Day
New Years Day	Juneteenth (June 19th)	Thanksgiving Day
Martin Luther King Jr. Birthday	Independence Day	Day After Thanksgiving
Presidents Day	Labor Day	****CHRISTMAS BREAK** (2 WEEKS)**

IMPORTANT NOTES:

- The Center will be **CLOSED** on the following Monday if a holiday falls on the weekend (Saturday or Sunday).
- **The Center will be CLOSED for two (2) weeks for Christmas Break from Monday December 23rd to January 3rd, 2025. Parents will NOT be charged for the Christmas Break.**
- **Refunds are NOT given for Center holidays or in-service training or day the child is absent.**

The Center Will:

- Give written notice in the event of any exposure to a contagious disease with the group.
- Administer prescription and non-prescription medications to children under the Child Care Administration regulations. If you require a "Medication Form" please contact the Office or your child's Teacher.
- Exercise reasonable care and judgement in all matters related to the welfare and safety of the child.
- In case of accident or illness, the teacher or assistant will take prompt and reasonable measures in the best interest of the child and will notify the parent/guardian as soon as possible.

- Provide breakfast, lunch, and afternoon snack.
- Provide educational activities to develop and enhance physical, emotional, social, mental, and moral development.
- Provide resources in sufficient quantity to allow for a variety of play and learning activities during the day.
- Our Center follows a policy of non-discrimination. No person is excluded from school attendance or employment because of race, color, or national origin.
- We accept children with special needs and will make reasonable efforts to accommodate them to the best of our ability. Our Center does allow therapists to come and work with the children.
- The Center **WILL NOT** release the child to anyone other than the parent or guardian unless written permission is received from the parent or guardian.

The Parent/Guardian(s) Agree:

- Tuition is due on **Monday each week** the child is enrolled in the program through Brightwheel. Because the child holds a slot in the program, tuition is still due whether the child is present or absent.
- Voucher co-payments are due on **Monday each week** through Brightwheel.
- **The parent/guardian(s) will pay a non-refundable applications and registration fee of $100 annually through Brightwheel to enroll and secure a position for his/her child.**
- **$__________**Will be paid every Monday through Brightwheel.
- If tuition is **NOT** paid by **Tuesday 5:30pm** (for the week your child is enrolled), your child **WILL NOT** be allowed to enter the Center until the tuition and late payment fee ($10 per day until Friday) are paid in full for that week.
- An activity fee may be charged from time to time depending on the types of trips taken during the school year.
- A book fee of $__________for the books for the school year.
- The Center will close at 5:30pm. This gives us the opportunity to thoroughly clean and sanitize the Center in preparation for the next school day.
- **If a child remains after 5:30pm, a late pick-up fee of $2.00 per minute per child will be charged. The individual picking up will be asked to sign a form stating the time and the parent/guardian will be responsible for payment of any late pick-up fees. The late pick-up fee is due the next day before the child enters the center.**
- The parent/guardian will **provide the required forms** from the enrollment packet **before the child can begin attending the center.**
- **Sick care is NOT available**. It is the parent/guardian's responsibility to make other arrangements when a child is ill. A teacher will observe the children daily for symptoms of contagious diseases or illnesses before they are admitted for the day. If a child has a fever (100.4 degrees or higher), that child will not be re-admitted until **fever free for 24 hours**.
- In the event that a child has a contagious illness, the parent/guardian will notify the Center. The child will not be allowed to return until the contagious period has passed. A doctor's note is **REQUIRED** for the child to return.

- In the event of an emergency, the Center has permission to take reasonable measures necessary for the welfare and safety of the child as determined by the judgment of the Teacher or Director.
- Parent/guardians can always correspond with your child's Teacher or the Office through Brightwheel or telephone.
- Each child is given a 30-day probationary period to allow them to adjust to the Center and for the Center to adjust to them.
- The Center reserved the privilege of dismissing any child, if after enrolling, he/she is unable to participate in group experiences and the daily program.
- It is the parent/guardian's responsibility to make sure that your child always has 2 extra sets of clothing - including underwear - at the Center (labeled with your child's name).
- **UNIFORMS** are **REQUIRED** by our Center to be worn by **ALL** preschool students (during the school year) unless otherwise stated. Students not in compliance may be dismissed from the Center.
- Parent/guardians are legally liable for their child's destructive or unlawful actions while at the Center.
- Because of the seriousness of body fluids and the safety of children and staff, I understand **that any child who bites others can and will be dismissed** from the Center at the discretion of the Directors.
- **Agape's Full Day Program begins at 9:00AM. Any child arriving AFTER 9:15AM will NOT be admitted, except in cases of scheduled doctors' appointments. In cases of scheduled doctor appointments, a doctor's note is required for admittance**.
- **It is the parent(s)/guardians' responsibility to make sure that the Center always has a current telephone number and contact information on file so that they can be reached in cases of emergency.**
- We will check your child INTO and OUT OF the Center on Brightwheel each day. Please ensure you have downloaded the app on your mobile device.
- Rules and regulations are subject to change and will be rearranged by the Administration to ensure safety for all.
- Cash payments are no longer accepted. All payments must be made through Brightwheel using debit or credit.

I (we) understand and agree to abide by the policies and procedures as stated in the Parent-Student Handbook and this Parent/Center agreement. I (we) also understand that from time to time the Center's Director may implement or change policies as needed. I understand that I will be notified of such changes.

I also understand that I can go to http://earlychildhod/marylandpublicschols.org/parentbrochureguide to download a copy of the Early Childhood Guide to Regulate Child Care.

Parent(s) Signature **Parent (Print Name)** **Date**

Director/Office Manager **Date**

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PICK-UP AUTHORIZATION

2024 – 2025

Parents, please indicate on this list the names of ALL persons who you authorize to pick-up your child from Agape' Early Childhood Learning, Development and Family Life Center. Please inform all people listed that identification might be required when coming to pick up your child. Most importantly, **please keep this list UPDATED so your child's record remains current**.

Childs Name: ______________________________

Below are the names of persons I authorize to pick up my child, ______________________
(Childs Name)

______________________________ ______________________
Parent(s)/Guardians Signature **Date**

____
Print Name

AUTHORIZED NAMES	TELEPHONE NUMBER	RELATIONSHIP TO CHILD
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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AUTHORIZATION FOR FIELD TRIP ACTIVITES AND TRANSPORTATION

AUGUST 2024 – AUGUST 2025

I, ______________________________________, hereby give Agape' Early Childhood Learning, Development and Family Life Center and its authorized representatives, permission to transport my child, _______________________________, on any field trips outside the Center by vans and authorized vehicles, as long as:

1. I am notified at least 24 hours in advance of the field trip.
2. I am given information regarding the time and location of the field trip activity.

I do understand and acknowledge that Agape' Early Childhood Learning, Development and Family Life Center will **NOT** be held responsible incase of injury during the field trip activity and transportation.

____

Parent(s)/Guardian Signature

____

Print Name

____

Date

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AUTHORIZATION TO USE PHOTOGRAPHS RELEASE FORM

I, ______________________________, hereby give Agape' Early Childhood Learning, Development and Family Life Center permission to use my/or my child(ren)'s , _______________________, photos for advertising and marketing (website, flyers, posters, etc.) purposes.

PLEASE NOTE: These pictures will **NOT** be sold by Agape' to any other companies.

______________________________ ______________________________

Parent(s)/Guardian Signature **Print Name**

______________________________ ______________________________

Title **Date**

OFFICE USE ONLY

____

Release Received By

____

Date

A Great Atmosphere and Place to Educate your children

Updated July 29, 2024

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:___ No:____

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

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 ______________

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

Any Changes/Additional Information______________________________

____

ANNUAL UPDATES ____________ ____________ ____________ ____________
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name ______________________ Telephone (H) ________ (W) ________
   Last First

   Address ______________________________
   Street/Apt. # City State Zip Code

2. Name ______________________ Telephone (H) ________ (W) ________
   Last First

   Address ______________________________
   Street/Apt. # City State Zip Code

3. Name ______________________ Telephone (H) ________ (W) ________
   Last First

   Address ______________________________
   Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care ______________________ Telephone ____________

Address ______________________________
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian ______________________________Date ______________

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

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: ______________________________

____

____

____

<u>Note to Health Practitioner:</u>

If you have reviewed the above information, please complete the following:

______________________________ ______________________________

Name of Health Practitioner Date

______________________________ (_____) ______________________________

Signature of Health Practitioner Telephone Number

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 DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: ____
LAST FIRST M I

STUDENT/SELF ADDRESS: ______________________________ CITY: ______________ ZIP: ________

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: ________/________/________

COUNTY: ______________________ SCHOOL: ______________________________ GRADE: ______

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: ______________________________ PHONE #: ____________________

#	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	DOSE #6
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	DOSE #7
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	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				______	______	______	______	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					______ ______	______	______ ______	______ ______	DOSE #5	DOSE #10

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

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

Clinic / Office Name
Office Address/ Phone Number

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: ____________________

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 or immunizations, 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: ______________________ (Last / First / Middle) **Birth date:** ________ (Mo / Day / Yr) **Sex** 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:			Birth Date:	Sex
Last	First	Middle	Month / Day / Year	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.

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/nceh/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/phpa/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

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

______________________ ______________________
Signature Date

2. ______________________ ______________________
Name Title

______________________ ______________________
Signature Date

Clinic/Office Name, Address, Phone

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

Environmental Health Bureau
mdh.envhealth@maryland.gov

DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

ALL ABOUT:______________________________

Child's First Name or Nickname

Child's Name: __________________ Birthdate: __________

Parent/Guardian: __________ Telephone: __________ Work: __________

Address: __________________ Zip: __________

Provider/Center: __________________ Telephone: __________

Address: __________________ Zip: __________

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES
MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES
THINGS MY CHILD MIGHT NEED HELP WITH
WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the ChildCare Facility when needed)

This information is intended for use by the child care provider, developed in cooperation with the parents. THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.

SIGNATURES:

Parent/Guardian: ______________________ Date: __________

Provider: ______________________ Date: __________

UPDATES:

Parent/Guardian: __________ Date: __________ Parent/Guardian: Date: __________

Provider: ______________________ Provider: ______________________