WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS
KIDS KLUB AFTER SCHOOL
Participant Registration Form

Program Site:_________________________________

School Child Attends ______________________________ Child's Age as of 9.5.2018 _____

Participant's Name ______________________________________ Phone _______________
Address ____________________________ City/State___________________ Zip Code_____
Birth Date __________________________ Grade ________ Male _______ Female ______

Mother/Guardian Name ____
Address ____________________________ City/State___________________ Zip Code________
Home Phone _____________ Work Phone ___________ Cell Phone __________________
Email____
Employer ____ Phone ___________

Father/Guardian Name ____
Address ____________________________ City/State___________________ Zip Code________
Home Phone _____________ Work Phone ___________ Cell Phone ______________________
Email____
Employer ____ Phone ___________

Would like to receive email updates on future activities from Wicomico County Recreation and Parks. __ Yes or __ No

Marital Status of Parents __ Single __ Married __ Separated __ Divorced
If Separated/Divorced, which parent has custody? ___________________________________
Is there a problem with either parent visiting, talking with or picking up participant?
__ No __ Yes If yes, explain

____
____
____

AUTHORIZED RELEASE

Are there any pick up concerns or things the staff should know? ___ Yes ___ No
If yes, please explain:

____
____
____

List names and contact information of individuals authorized to pick your child up (other than parents):

Name	Phone Number(s)	Relationship to Child

Please let those authorized to pick up to bring in their State issued identification when picking up your child. If the individual picks up occasionally they will be asked for identification every time they come to pick up your child up. If you need to remove or add someone to this list please contact your site director or the program director at 410.548.4900 X109 or at bbelfield@wicomicocounty.org.

ELIGIBILITY FOR AFTER SCHOOL PROGRAM

The Wicomico County Recreation and Parks is required to make reasonable accommodations for all participants in this program. The next few questions are asked to make sure your child has found an after school program that matches his or her needs and provides a safe and suitable environment. We do not provide additional staff or resources for individual needs.

Can your child participate in all activities? ___ No ___ Yes

Does your child need any special accommodations? ___ No ___ Yes

If yes, please explain

____

Please check any of the following that apply:

__ Hearing Aid	__ Uses Sign Language	__ Needs Assistance w/Walking
__ Wears Braces	__ Use Crutches/Walker	__ Needs Assistance w/toiletry
__ Wears Diapers	__ Has Speech Impediment	__ Needs Help Dressing
__ Speaks little English	__ Menstruates	__ Needs Help with Feeding
__ Uses Wheelchair (manual or electric)		___ Requires Additional Adult Support in School

Is your child on medication? __ No __ Yes
If Yes, what type? ____
When given? ______________________ Who administers? ______________________

Our staff cannot administer medication. We are only permitted to supervisor self-medication. You must have a current Medication Administration Authorization Form on file before Kids Klub Staff will accept any medication for your child this includes inhalers and other emergency medications. Kids Klub Staff does not offering diapering or assistance in the restroom.

Does your child have seizures? __ No __ Yes
If Yes, how often? ______________________ How severe? ______________________

Are there any significant medical or behavioral problems that we need to be aware of? __ No __ Yes
If Yes, please explain ____

If your child is enrolled in a Special Education program, what is their Special Education Classification?

____

Do you have any additional comments that would help us to know or assist your child?

____

____

****Please check with the Program Director of the Kids Klub After School if you have questions about any of the above questions in this section. 410-548-4900 x 109.**

ADDITIONAL INFORMATION

Does your child have any allergies or diet restrictions? __ Yes __ No
If yes, explain____

Does your child have specific fears? __ Yes __ No
If yes, explain____

May we have permission to use photographs of your child for camp publicity purposes?
__ Yes __ No

Is your child exempt from immunizations for religious or medical reasons ____ No ____ Yes
If yes, please explain____

****Please check with the Program Director of Kids Klub After School if you have questions about any of the above questions in this section. 410-548-4900 x 109 or bbelfield@wicomicocounty.org**

KIDS KLUB AFTER SCHOOL WAVIERS & CONSENT FORMS

CONCUSSION WAIVER

In compliance with Maryland HB 858 and SB 771, I hereby acknowledge that I have received the information regarding concussions published by the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC). Handout with additional information regarding concussions provided in parent handbook.

Participant's Name ____________________________

____________________________ Participant's Signature (If 18 or over)

____________________ Date

____________________________ Parent/Guardian Signature

____________________ Date

PHOTO RELEASE

I hereby grant Wicomico County, Maryland permission to use my likeness in a photograph, video or other digital reproduction in any and all of its publications, including any website entries and social media, without payment or any other consideration.

I understand and agree that these materials will become the sole property of Wicomico County, Maryland and will not be returned. I hereby irrevocably authorize Wicomico County, Maryland to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing its programs or for any other lawful purpose.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge Wicomico County, Maryland from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

____________________________ Signature

____________________ Date

____________________________ Printed Name

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of ________________________ (Child's Name), named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

____________________________ Parent/Guardian's Signature

____________________ Date

____________________________ Parent/Guardian's Printed Name

****Please check with the Program Director of Kids Klub After School if you have questions about any of the above questions in this section. 410-548-4900 x 109 or bbelfield@wicomicocounty.org**

EMERGENCY CARE CONSENT FORM

In case of illness or accident while my child is under the care and supervision of the After School Program, I the undersigned, hereby consent to the Wicomico County Department of Recreation and Parks authorized staff to provide emergency first aid and/or administer emergency care and/or treatment through a clinic, a doctor and/or hospital should they feel it is advisable or necessary. I also agree to pay all of the cost and fees contingent upon an emergency medical care and/or treatment for my child as secured or authorized under this consent. This agreement shall continue as long as the participant is registered in the After School Program.

Name of Parent/Guardian ___________________________________

___________________________________ Signature of Parent/Guardian

___________________ Date

PERMISSION FOR TRIPS, EXCURSIONS AND USE OF PUBLIC PARKS AND FACILITIES

I hereby given consent to the W/C Department of Recreation & Parks After School Program to take my child on walking or transported field trips to places of interest, including public parks, with such understanding that such trips are under the supervision of authorized After School Program personnel and that all possible precautions are taken to ensure the health and safety of my child.

Name of Parent/Guardian ___________________________________

___________________________________ Signature of Parent/Guardian

___________________ Date

HOW DID YOU HEAR ABOUT KIDS KLUB AFTER SCHOOL

(Check all that apply)

___ Banner at school site ___ YouTube/ Facebook ___Flyer in Mail

___ School PTA ___ School Office ___ Brochure at School

___ Blog (Rec Round Up) ___ Word of Mouth ___ Previously Attended

___ Kids Klub Summer Escape ___ Rec & Parks Website ___ Other ________________

WAVIER

I further agree that the medical information given above is correct. The undersigned do hereby expressly stipulate and agree to indemnify and hold forever harmless Wicomico County and the Wicomico County Department of Recreation, Parks and Tourism, its agents, officers and employees, against loss from any and all claims, demands, or actions in law or equity that may hereafter at any time be made or brought by the participant listed above, or by anyone on behalf of said participant for the purpose of enforcing a claim for damages on account of any injuries received or sustained by the participant arising out of his participation in the program. In signing this Release and Hold Harmless Agreement, each of the undersigned hereby acknowledges and represents that they are aware of the risks and hazards inherent in participating in the program, that no insurance covering accident or injury has been provided for participants, that arrangements for any such insurance would have to be made individually by the undersigned, and that at no time will my participation in a program be contingent on divulging **any** confidential medical information.

Name of Parent/Guardian ___________________________________

___________________________________ Signature of Parent/Guardian

___________________ Date

****Please check with the Program Director of Kids Klub After School if you have questions about any of the above questions in this section. 410-548-4900 x 109 or bbelfield@wicomicocounty.org**

Parent Contract
WICOMICO COUNTY DEPARTMENT OF RECREATION, PARKS AND TOURISM

Child's Name: ______________________ Program: Kids Klub After School Program 2018- 2019

Please review the information below to ensure that you understand your responsibilities in enrolling your child in a Wicomico County Recreation, Parks and Tourism Summer Camp Program. A copy of this will be provided for your records upon request. Please initial each item. Also, print and sign your name and date on page.

_________ 1. All monthly payments are due the first school day of the month this is regardless if your child is present that day or not. Payments received after the due date will be considered late and result in a $15.00 late fee per child. You may pay early on line, at the box office or at your site.

_________ 2. Late payments will not be at the Kids Klub sites. Late payments will have to be made at the Box Office or on line at https://www.wicomicorecandparks.org/.

_________ 3. Electronics, including cell phones will not be allowed at Kids Klub. Children will be asked to put all electronics away in their bags or leave them at home. Wicomico Country Recreation and Parks is not responsible for lost, damaged, or stolen property.

_________ 4. I understand that if my child breaks or damages equipment that belongs to Wicomico County Board of Education or Wicomico Country Recreation, Parks and Tourism, or another participant I am responsible for the costs.

_________ 5. Repeated late pick up may result in removal from the program. Kids Klub ends promptly at 5:30PM. If removed from the program **refunds will not be made under these circumstances. If you keep the staff past 5:30PM you will be charged a late fee.**

_________ 6. I understand that Kids Klub is closed when the schools are closed.

_________ 7. I understand that I may be asked to withdraw my child if their behavior patterns threaten their own health and safety or that of other children and staff. **Refunds will not be made under these circumstances.**

_________ 8. I understand that bullying and or threats violence will not be not tolerated and is grounds for suspension and or removal from the program. **Refunds will not be made under these circumstances.**

_________ 9. I understand that my child cannot attend the program if he / she has any illness that threatens the health of other children or staff. Regulations concerning periods of infection will be enforced.

_________ 10. I understand that if my child becomes ill during the program, it is my responsibility to arrange immediate pick up from the program. I understand that they cannot return to the program until he or she is well and or cleared by a doctor in severe cases.

_________ 11. If your child is found to have lice they will be sent home immediately. Your child will not be allowed to return until they are lice and nit free and you must supply a doctor's note or the box lid of the given treatment.

_________ 12. I understand that it is my responsibility to send my child with the appropriate attire which includes closed toe shoes (i.e. tennis shoes) if needed. Flip flops, sandals and some non-sneakers (boots, dress shoes, etc.) are not considered appropriate and are unsafe to participate in physical activity and pose an increased risk of injury.

_________ 13. I understand that Kids Klub Staff should only be contacted during Kids Klub hours. Parents should not contact Kids Klub staff outside of those hours. Please contact the Civic Center Box Office or the Program Director during normal business hours, Monday through Friday at 410.548.4900 if you need assistance during those hours.

_________ 14. I understand that medication will not be administered by staff. If your child requires medication during program hours, you must supply the Medication Administration form. This includes emergency medications such as inhalers and epi pens. He or she must be able to administer the medication without assistance from the staff. The Medication Authorization form is available upon request.

_________ 15. I understand that no children are excluded from activities that are planned based on their abilities. Please provide an IEP or Behavior Intervention Plan if one is written. This is kept confidential and is only used for planning purposes. Activities can be modified based on child's individual needs and guided by the IEP if one is available. Please note we do not offer one on one care and **reasonable accommodations are made.**

_________ 16. **Wicomico County Recreation and Parks Child Care and Summer Camp programs follows the Board of Education policy on smoking, drugs, and alcohol on school and county grounds. Use of the before mentioned substances is grounds for immediate removal from the program. Refunds will not be made under these circumstances.**

_________ 17. Discipline procedures are followed with the Board of Education guidelines. However, Wicomico County Recreation, Parks and Tourism reserves the right to remove a child from the program if the safety of that child and or other children in the program or staff are at risk. **Refunds will not be made under these circumstances.**

_________ 18. I understand that if my child receives **a write up**, it is up to the program director if the child will be suspended or removed from the program. If the child is removed from the program, **refunds will not be made under these circumstances.**

I _________________________________ (Parent or Guardian's Name Printed) agree to abide by the Code of Conduct set forth by the Wicomico County Department of Recreation and Parks. I am aware that I may request a copy of this Code of Conduct at any time.

I AGREE TO ADHERE TO THE WICOMICO COUNTY DEPARTMENT OF RECREATION, PARKS AND TOURISM'S KIDS KLUB AFTER SCHOOL PROGRAM PARENT CONTRACT FOR THE 2018-2019 SCHOOL YEAR.
I GIVE MY CHILD PERMISSION TO PARTICIPATE IN THIS PROGRAM.

Parent Signature: ___________________________________ Date: __________

A copy of this is provided in the parent handbook for your records

Discipline Agreement: Kids Klub 2018-2019 School Year

Kids Klub Copy

PLEASE READ THIS IN ITS ENTIRETY

To our new participants as well as returners, we welcome you to our program and are looking forward to an exciting school year here at Kids Klub! This document is our site's discipline agreement for the school year of 2018-2019. You are receiving this document so that you and your child(ren) can become familiar with our site's specific rules and consequences. Once you and your child(ren) have signed this slip, we will consider this a contract between staff, participants, and parents. Children will sign this once reviewed with a staff member. Parents, please discuss this with your child before they attend our program. A copy will be provided in your parent handbook.

The following are the Kids Klub After School rules that both staff and participants have collaborated on for the safety and enjoyment of our program.

Rules

9. Show respect to Kids Klub staff, participants and school staff members at all times.
10. Follow all directions the first time they are given.
11. **Keep hands, feet, and unkind words to yourself.**
12. Every day at Kids Klub we will start our homework and eat a snack.
13. Remain seated and quiet during homework and down time.
14. Use walking feet in the cafeteria and hallways.
15. Be honest and responsible.
16. Be kind and fair to everyone.

If a child chooses to break a rule:

- 1st and 2nd time: **Sit out** (1-3 times depending on the behavior) or removal from the current activity
- 3rd time: **Talk with Parent(s)** The child will tell parent(s) what happened when being picked up while Kids Klub counselor is present
- 4th time: **Behavior write up** depending on the behavior a behavior write up will be given and child will tell parent(s) what happened
- *Severe* disruption or misbehavior includes but not limited to:
  - Cursing/inappropriate language
  - Physical violence with another student or counselor
  - Bullying of any kind
  - Destruction of school, Wicomico County Parks and Recreation, or personal property of another student

***Bullying of any kind will not be tolerated at any Kids Klub site. Kids Klub defines bullying as physically intimidating or hurting another participant, repeatedly calling names or taunting others after being asked to stop, targeting others with the intention of excluding them from group activities or taking their personal belongings.*

*** Any severe disruption or misbehavior will be written up **immediately** and is susceptible to suspension from the program. Depending on severity of the behavior, the parent may be called in order to have the child removed for the remainder of the day.*

Any child that receives **2 or more behavior write ups within a week is at the risk of being suspended from the program for a specified number of days.

** Multiple write ups may result in suspension or removal from Wicomico County Recreation and Parks Child Care Programs.

** Depending on the severity, a child may be removed from the program for a 1st time offense.

Please review these expectations and penalties with your children. Have you and your child(ren) sign below and return this form ASAP.

CHILD: I have read the discipline plan and understand it. I will honor it while at Kids Klub each day.

Signature: ______________________ Date: __________

PARENTS: I will discuss this Discipline Agreement with my child. I understand it and will support it. A copy is provide in your parent handbook.

Signature: ______________________ Date: __________

STAFF MEMBERS: We will be fair and consistent in executing the discipline plan at Kids Klub.

Signature: ______________________ Date: __________

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents 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 __________

Child's Name ______________________ Birth Date __________
Last First

Enrollment Date __________ Hours & Days of Expected Attendance __________

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

Mother's Name ______________________ Home Telephone __________
Last First

Mother's Employer/School ______________________
Name Address

Mother's Home Address (*If different from above*) ______________________
Street/Apt.# City State Zip Code

Work Telephone __________ Cellular Phone __________ Beeper __________

Father's Name ______________________ Home Telephone __________
Last First

Father's Employer/School ______________________
Name Address

Father's Home Address *(If different from above)* ______________________
Street/Apt.# City State Zip Code

Work Telephone __________ Cellular Phone __________ Beeper __________

Name of Person Authorized to Pick Up Child *(daily)* ______________________
Last First Relationship to Child

Address ______________________
Street/Apt.# City State Zip Code

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

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________ Date of Birth: ______________

Medical Condition(s): ______________________

____

Medications currently being taken by your child: ______________________

____

Date of your child's last tetanus shot: ______________________

Allergies/Reactions: ______________________

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________

____

(2) If signs/symptoms appear, do this: ______________________

(3) To prevent incidents: ______________________

____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________

____

____

____

COMMENTS: ______________________

____

____

____

____

Note to Health Practitioner:

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

______________________ Name of Health Practitioner

______________________ Date

______________________ Signature of Health Practitioner

(_____)______________________ Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- ***A physical examination** by a 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☐ F☐

Address: ______________________________
Number Street Apt# City State Zip

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

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	Name:	Physical Exam:
Address:	Address:	Dental Care:
Phone #	Phone	Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ 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: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

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	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

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_dhmh_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 ☐ Yes ☐ 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)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

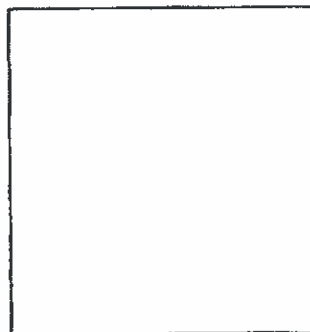
Wicomico
ALL

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



Child's Picture (Optional)

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.**

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 ______________
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain ______________________________

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 Heath Care Plan Received: ☐ YES ☐ NO

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

OCC 1216 (Revised 08/20/15) – *All previous editions are obsolete.)*

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	Date of Birth:
Medication Name:	Dosage:
Route:	Time(s) to administer:

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

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.

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: ______________

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. (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. (Choose Immunization in the A-Z Index)

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)

Triggers (list)

____
____
____
____
____
____
____

Student's Name: ______________________________ DOB: ______________ PEAK FLOW PERSONAL BEST: ______________

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

	Medication	Dose	Route	Frequency
☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other. ______________ ☐ Peak flow greater than _______ (80% personal best)				
☐ Prior to exercise/sports/ physical education	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms	Medication	Dose	Route	Frequency
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other ______________				
☐ Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in ______ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

	Medication	Dose	Route	Frequency
☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Other ______________ ☐ Peak flow less than __________ (50% personal best)				
	Contact the parent/guardian after calling 911.			

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications: (School-age children) ☐Yes ☐No

Prescriber signature: ______________________ Date: ________ Parent / Guardian Signature: ________________ Date: ________

Reviewed by Child Care Provider: Name: ______________________ Signature: ______________________ Date: ________

3/20/2014