



# *I.M.P.R.O.V.E. Children Summer Program*

*"2023"*

## CONTRACT

**Payments must be in the form of cash, money orders or cashier checks.**

I, \_\_\_\_\_, agree that the I.M.P.R.O.V.E. Children Program (ICP) at Loch Raven United Methodist Church will provide childcare for my child/children \_\_\_\_\_, June 26, 2023 – August 18, 2023. I understand that the program will close on Monday & Tuesday July 3 & 4<sup>th</sup> in observance of the Fourth of July Holiday. We will close at 12:30 pm on Friday, August 18, 2023 (the last day of camp).

For this service I agree to pay ICP \$\_\_\_\_\_ per week. Payments must be made 2 weeks in advance. Payments are due every other Monday. Scholarship out of pocket fees are due the first of every month. A \$30.00 per day late fee will be charged for late payments. If I exceed the designated time for picking up my child, I will be obligated to pay an extra \$30.00 for every 15 minutes per child for extended care. If my child arrives at the program before 7:30 am, I am responsible for paying an extra fee of \$15 per day, unless I sign up for before care which is an extra \$25 per week. I understand that refunds are not given (for any reason) if I decide not to send my child to the program on the days in which ICP is responsible for caring for my child/children.

The I.M.P.R.O.V.E. Children Program understands that this is peak vacation time for most families. Therefore, we will allow your child to be absent for one week, (Mon – Fri) in which you will only be responsible for ½ weeks payment. We must receive a letter at least 2 weeks prior to vacation time with the vacation dates written down. If the program is not notified at least two weeks before your child’s vacation, you will be responsible for the full payment. Vacation fees are only allowed for children who are enrolled in the 8 week session.

A free nutritious breakfast, lunch and snack will be provided for 8 weeks. If you choose to send a lunch with your child, it must be a cold lunch, with an ice pack. We will not let children eat perishables that are not stored in their lunch boxes correctly. Also, we do not heat food.

During summer, masks will be optional. However, if we feel the need to reinstate the mask policy, all staff and children will be required to comply. If we believe your child is starting or getting over a contagious upper respiratory illness, we will give them a mask.

We respectfully ask all parents and adults who are designated to pick up and drop off children to not enter in the church building under the influence or smelling of drugs (marijuana) and alcohol. If this request is ignored by parents, or guardians who pick up children, your child’s contract will be terminated by IMPROVE and Ms. Viola will meet with you, if needed. We understand that marijuana is sometimes used for medicinal purposes, however, please keep in consideration the side effects that the smell can have on the children, staff, and younger siblings of the families who may be present. If you have any questions about this policy, please contact Ms. Viola via her cellular phone: 410-215-4604.

Parent/Guardian Name: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_



# IMPROVE CHILDREN PROGRAM

## “202\_\_-202\_\_” REGISTRATION FORM

*\*Please circle one: Summer Camp or Before/Afterschool Program Date:* \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Wk. Address: \_\_\_\_\_ Wk#: \_\_\_\_\_

Other # \_\_\_\_\_ Parent's E – mail address: \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Wk. Address: \_\_\_\_\_ Wk#: \_\_\_\_\_

Other # \_\_\_\_\_ Parent's E – mail address: \_\_\_\_\_

Emergency Contact Person (PLEASE USE BACK FOR ADDITIONAL EMERGENCY CONTACTS, IF NOT ENOUGH SPACE)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Other#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Other#: \_\_\_\_\_

What is your child's favorite activity and foods they like to eat?

Does your child play well with others?

Do you think your child will benefit from stress and time management class?

Does your child occupy his/her time in a positive way?

Does your child have any medical problems (asthma, allergies etc.)?

Please explain \_\_\_\_\_

Does your child take medication for any reason?

Please explain \_\_\_\_\_

Is your child allergic to any particular food?

Does your child have any special needs? \_\_\_\_\_

Does your child have an IFSP/IEP, if so would you like to provide all or part of the IFSP/IEP? \_\_\_\_\_

Is there any other important information we need to know about your child? \_\_\_\_\_

**IF YOUR CHILD HAS HAD ASTHMA IN THE PAST OR CURRENTLY HAVE ASTHMA, WE  
MUST HAVE AN INHALER FOR THEM AT ALLTIMES !**

UPDATED JUNE 2022

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**

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
<b>Address:</b> _____			Mo / Day / Yr		
Number	Street	Apt#	City	State	Zip
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>	<b>Phone Number(s)</b>		
		W:	C:	H:	
		W:	C:	H:	
<b>Medical Care Provider</b> Name: Address: Phone:		<b>Health Care Specialist</b> Name: Address: Phone:	<b>Dental Care Provider</b> Name: Address: Phone:	<b>Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child Care Scholarship</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Last Time Child Seen for Physical Exam:</b> <b>Dental Care:</b> <b>Specialist:</b>
<b>ASSESSMENT OF CHILD'S HEALTH</b> - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	<b>Comments (required for any Yes answer)</b>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
Printed Name and Signature of Parent/Guardian _____					Date _____

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

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

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?  
 No     Yes, describe:

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2. Does the child receive care from a Health Care Specialist/Consultant?  
 No     Yes, describe

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_  
 LAST FIRST MI

SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT OR GUARDIAN NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4						
5	DOSE #5												

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

Clinic / Office Name  
 Office Address/ Phone Number

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

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

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

**MEDICAL CONTRAINDICATION:**

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

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

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

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

**RELIGIOUS OBJECTION:**

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

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

## How To Use This Form

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

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

### Notes:

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

## Immunization Requirements

The following excerpt from the 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](http://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](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)





## HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

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

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

### **Lead Risk Assessment Questionnaire Screening Questions:**

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

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

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

Place Child's  
Picture Here  
(optional)

**PRESCRIBER'S AUTHORIZATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Medications shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If PRN, for what symptoms, how often and how long \_\_\_\_\_

Possible side effects and special instructions: \_\_\_\_\_

Known Food or Drug Allergies:  Yes  No If yes, please explain: \_\_\_\_\_

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

The child may self-administer this medication:  Yes  No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

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

**PARENT/GUARDIAN AUTHORIZATION**

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

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

**CHILD CARE STAFF USE ONLY**

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

Reviewed by (printed name and signature): _____	DATE (mm/dd/yyyy) _____
---	-------------------------

Maryland State Department of Education

Office of Child Care

MEDICATION ADMINISTRATION LOG

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

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

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

1. CHILD'S NAME (First Middle Last) _____	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____	3. Child's picture (optional)	
4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ____% 5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____			
<b>Section I. ASTHMA ACTION PLAN</b>			
6. FOR ASTHMA MEDICATIONS ONLY - THIS FORM REPLACES OCC 1216. This authorization is NOT TO EXCEED 1 YEAR			
GREEN ZONE - DOING WELL: Long Term Control Medication - Use Daily At Home unless otherwise indicated <input type="checkbox"/> OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No			
The Child has <b>ALL</b> of these <input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)			
Exercise Zone <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it			
YELLOW ZONE - GETTING WORSE <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No			
The Child has <b>ANY</b> of these <input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)			
RED ZONE - MEDICAL ALERT/DANGER <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No			
The Child has <b>ANY</b> of these <input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)			



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:	W:
			H:	Employer:
			H:	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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

# For questions, concerns or to file a complaint contact your regional office

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worcester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at [CheckCCMD.org](http://CheckCCMD.org).

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

## Resources

**Child Care Subsidy** - Assists parents with cost of childcare  
**1-866-243-8796**

**Consumer Product Safety Commission (CPSC)** - regulates certain products used in childcare  
**[cpsc.org](http://cpsc.org)**

**Maryland EXCELS** - Maryland's Quality Rating System for Childcare Facilities  
**[marylandexcels.org](http://marylandexcels.org)**

**Maryland Developmental Disabilities Council** - May assist with ADA issues  
**[md-council.org](http://md-council.org)**

**Maryland Family Network** - Assists parents in locating childcare  
**[Marylandfamilynetwork.org](http://Marylandfamilynetwork.org)**

**PARTNERS Newsletter** - What's happening in the Division of Early Childhood Development  
**[Earlychildhood.Marylandpublicschools.org](http://Earlychildhood.Marylandpublicschools.org)**

To this site to check provider inspection violations  
**[checkcmd.org](http://checkcmd.org)**



Larry Hoggan, Governor

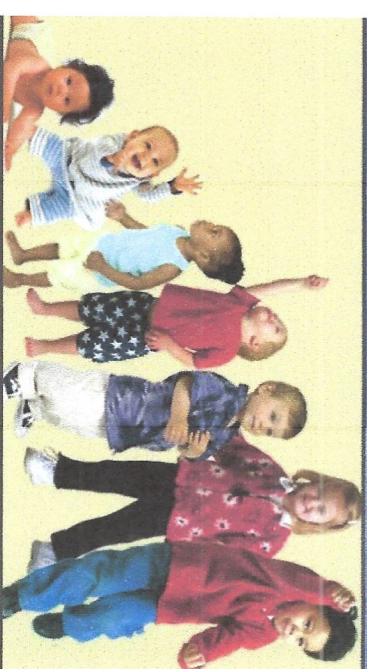
Mohammed Choudhury

State Superintendent of Schools

OCC 1524 (10/2018)

# Guide to

# Regulated Child Care



**Important**

**Information**

**About Child**

**Care Facilities**



## Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's (OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary.

**COMAR Regulations and other information about the Office of Child Care may be found at:**

[earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care](http://earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care)



## What are the types of Child Care Facilities?

**Family Child Care** – care in a provider's home for up to eight (8) children

**Large Family Child Care**— care in a provider's home for 9-12 children

**Child Care Center** – non-residential care

**Letter of Compliance (LOC)** – care in a child care center operated by a religious organization for children who attend their school

**All facilities must meet the following requirements:**

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

## Did You Know?

- Regulations that govern child care facilities may be found at:  
[earlychildhood.marylandpublicschools.org/regulations](http://earlychildhood.marylandpublicschools.org/regulations)

- The provider's license or registration must be posted in a conspicuous place in the facility;

- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;

- Parents/guardians may visit the facility without prior notification any time their children are present;

- Written permission from parents/guardians is required for children to participate in any and all off property activities;

- All child care facilities must make reasonable accommodations for children with special needs;

- A "Teacher" qualified person must be assigned to each group of children in a child care center;

- Staff:child ratios must be maintained at all times in child care centers;

- Parents/guardian must be immediately notified if children are injured or have an accident in care;

- Child care facilities may have policies beyond regulatory requirements;

- OCC should be notified if a provider has violated child care regulations;

- Parents/guardians may review the public portion of a licensing file; and

- The provider's compliance history may be reviewed on [CheckCMD.org](http://CheckCMD.org).



## IMPROVE CHILDREN PROGRAM

6622 Loch Raven Boulevard

Baltimore, Maryland 21239-1498

410-825-3028

Email: [IMPROVECHILDREN@ymail.com](mailto:IMPROVECHILDREN@ymail.com)

- All Staff must arrive 10 minutes early to be assessed and have temperatures checked everyday before work.
- Parents and Visitors are not allowed in the building.
- All rooms will be disinfected 3 times a day
- All parents must allow 15 minutes for child to be assessed and temperature to be taken when dropping child off.
- All parents must sign waiver/consent before child can be enrolled in IMPROVE Children Program.
- Parents must provide 3 emergency contacts that can pick the child up within 15 minutes of being notified if the child becomes ill while in our care.
- Staff must monitor each child's hand washing procedure to assure that they are washing their hands properly.
- All support staff (Aides), will be available in a distant location with walkie talkies to escort children to rest rooms, clean and move supplies from room to room while respecting social distancing and performing other duties when necessary.
- Additional Hygiene (hand washing) time will be added to the daily schedule after hands on activities.
- Lead staff will occupy the foyer during peak dismissal and arrival times to assure that no visitors or parents try to enter the building and to make sure kids are assessed properly. The Inner door will remain locked at all times. New door codes will not be shared under any circumstances.
- IMPROVE will follow CDC guidelines for probable COVID cases. Please inform TJ or Ms. Viola if you would like a copy of the CDC guidelines.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Revised May 19, 2021

IMPROVE Children Program  
covid Consent Waiver 2021  
The IMPROVE CHILDREN PROGRAM  
6622 Loch Raven Blvd. 21239

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
Parents' Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Your child's Health and Safety is the number one priority of The IMPROVE Children Program, we will go above and beyond the limits for your children while they are in our care at THE IMPROVE CHILDREN PROGRAM. Rooms that your child/children use will be disinfected at least three times a day, twice after activities and once after all children leave the building. Your child will consistently be taught social distances exercises and lessons, in order to keep them safe and healthy. Room sizes will be in accordance with MSDE (Maryland State Department of Education) & OCC (office of childcare) regulations. We will encourage social distancing in the classroom as well as transitioning outside the classroom to other activities such as gym and outside. However COVID 19, is a virus that cannot be seen, therefore, we do not have total control of the spread of the virus. For this reason we are requiring all parents to sign this waiver/consent, prior to enrolling their child/ children in our program.

I hereby give consent and permission for my child \_\_\_\_\_ to be enrolled and participate in The Improve Children Program. In consideration of permitting my child, \_\_\_\_\_ to participate in The IMPROVE Children Program and use the facilities of Loch Raven United Methodist Church located at 6622 Loch Raven Blvd. 21239, I, myself, my heirs, executors, administrators, and assignees, waive and release forever any and all rights for claims and damages which I and my child may have against Loch Raven United Methodist Church, IMPROVE Children Program, The Improve Children Program 2 and The United Methodist Church, and their respective employees, servants, officials, agents, and officers, and officials, in any manner due to any personal injuries, illnesses, or property loss, sustained by my child in connection with the participation in said program and the use of said facilities. I attest that my child will abide by the rules and regulations of The IMPROVE Children Program. As the parent/guardian of minors, I shall sign for the minor(s) and assume all responsibilities which are listed above. If your child has any questionable illness or conditions, it is recommended that you consult the child's physician before enrollment and by signing this waiver/consent you agree to assume any potential risk associated with your child's participation.

- I will allow 15 minutes every morning when dropping my child off for IMPROVE to assess my child and take their temperature.
- I will not send my child the IMPROVE if he/she is ill
- I will pick my child up within 15 min of being notified, if my child becomes ill at IMPROVE.
- I will notify The Director immediately if I become aware that my child has come in contact with anyone with COVID 19 and remove my child from The IMPROVE Children Program for the quarantine period which according to the Center for Disease Control to date is 14 days.

PARENT/GUARDIAN NAME: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_



## PARENTAL CONSENT FORM

The I.M.P.R.O.V.E. Children Program has my consent to the following:

Photograph and/or record my child/children for, but not limited to, resources such as computers, books, pamphlets, websites, newsletters, grants, thank you letters, etc..

Yes  No

Face paint my child/children.

Yes  No

I will notify the staff of the I.M.P.R.O.V.E. Children Program **immediately** of any changes to any and all documents e.g., new contact information, medical conditions, special needs, etc...

Yes  No

Allow my child/children, if they are 11 years of age or older, to watch PG-13 rated movies at the I.M.P.R.O.V.E. Children Program.

Yes  No  N/A

Child/Children Name: \_\_\_\_\_

Parent's Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

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



## ***I.M.P.R.O.V.E. CHILDREN PROGRAM***

6622 Loch Raven Blvd

Baltimore MD. 21239

40-825-3028

Email: [ImproveChildren@ymail.com](mailto:ImproveChildren@ymail.com)

### **DISCIPLINE PROCEDURES AND POLICIES**

The I.M.P.R.O.V.E. staff is committed to providing a safe, positive and structured environment for all children in our Before-care, After-care and Summer programs. Although I.M.P.R.O.V.E. Before, Aftercare and Summer Camp have different schedules, appropriate student behavior is expected during each.

Please review the following rules and consequences for I.M.P.R.O.V.E. and discuss them with your child.

1. Show respect at all times to staff and peers.
2. Follow instructions set forth by staff/center.
3. Refrain from damaging school/church property.
4. Refrain from disruptive behavior and inappropriate language.
5. Comply with any and all other regulations set forth by I.M.P.R.O.V.E.'s Director/Owner/Board members and Loch Raven United Methodist Church.

I.M.P.R.O.V.E. staff will make every effort to communicate with parents/guardians when disciplinary action needs to be taken.

Please know that all rules will be reviewed with students at the beginning of the school year/summer camp. It is imperative that both the students and the parents understand the expectations of I.M.P.R.O.V.E. as well as the potential consequences.

- 1st The assistant Director or staff will contact parent regarding child behavior.
- 2nd Director/Owner will contact parent by phone to schedule meeting
- 3rd A warning letter will be send to parent
- 4th Fourth occurrence will result in suspension from before/aftercare/summer camp

A total of four occurrences can result in permanent dismissal from the I.M.P.R.O.V.E. Children Program.

Please date and sign below to acknowledge that you have read, understand and comply with the above policies and procedures.

Signature: \_\_\_\_\_

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



6622 Loch Raven Blvd  
Baltimore MD. 21239  
410-825-3028  
[Improvechildren.org](http://Improvechildren.org)

Dear IMPROVE Parents,

We know how important it is to stay up to date on your child's learning journey, which is why we're excited to introduce the Procure Solutions' app.

Once you download the Procure app on your smartphone, we can update you on your child's activities, send you photos and videos of your child/children, update you on any incidents, as well as make you aware of upcoming events and time-sensitive information, through the app.

The app also offers several "contactless" ways to check your child in and out (NO MORE SIGN IN AND OUT BOOK 📖). This helps us limit in-person interaction and unnecessary foot traffic in the center so we can better ensure the health and wellbeing of you, your children and our staff.

To get the app, simply text TJ (410-900-5584) your email address. You'll receive an email with all the instructions including a unique **4-digit pin** that you or anyone you designate to pick up your child can use to sign them in and out. You will receive information to download the mobile app via email.

We think you'll really enjoy this new way for us to stay connected!

Sincerely,  
The IMPROVE Children Program