



***I.M.P.R.O.V.E. Children Summer Program***  
***"2026"***  
**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 29, 2026 – August 21, 2026. I understand that the program will close on Friday July 3 & Monday July 6 in observance of the Fourth of July Holiday. We will close at 12:30 pm on Friday, August 21, 2026 (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 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 fee is 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 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 cannot heat food. Food deliveries are not allowed. Having food delivered to the program for your child can be very inconvenient for the staff and our lunch schedule, therefore, it will not be allowed this summer.

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 ” REGISTRATION FORM

*\*Please circle one: Summer Camp or Virtual Learning 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 ALL TIMES !**

UPDATED January 2021

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:
			C:	W:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Last First State Zip Code Street/Apt. # City

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 \_\_\_\_\_

**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



## ***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: \_\_\_\_\_



## 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: \_\_\_\_\_

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"/>
Address: _____ Last First Middle			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 - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.</b>					
	Yes	No	Comments (required for any Yes answer)		
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.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					Date _____

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

<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



STUDENT/SELF NAME: \_\_\_\_\_

LAST FIRST MI

STUDENT/SELF ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: MALE  FEMALE  OTHER  BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**FOR MINORS UNDER 18:**

PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

#	DTP-DTAP- DT Mo/Day/Yr	Polio Mo/Day /Yr	Hib Mo/Da y/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #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	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	DOSE #3	DOSE #3
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #4
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #5
									DOSE #2		DOSE #3			

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name  
Office Address/ Phone Number

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

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

**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)



# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

## How To Use This Form

- A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

## Frequently Asked Questions

### 1. Who should be tested for lead?

All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

### 2. What is the blood lead reference value, and how is it interpreted?

Maryland follows the [CDC blood lead reference value](#), which is 3.5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ). However, there is no safe level of lead in children.

### 3. If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?

Yes, if a capillary test shows a blood lead level of  $\geq 3.5 \mu\text{g}/\text{dL}$ , a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See [Table 1](#) (CDC) for the recommended schedule.

### 4. What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?

Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (<https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm>).

### 5. What programs or resources are available to families with a child with lead exposure?

Maryland and local jurisdictions have programs for families with a child exposed to lead:

- Maryland Home Visiting Services for Children with Lead Poisoning
- Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: <https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx>.

Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention: <https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx>

Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.

Phone: (610) 519-3478 or Toll Free: (833) 362-2243

Website: <https://www1.villanova.edu/university/nursing/macche.html>



**Maryland 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)
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Maryland State Department of Education  
Office of Child Care  
**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)

**Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

4. ASTHMA SEVERITY:  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise Induced  Peak Flow Best \_\_\_\_ %

5. ASTHMA TRIGGERS (check all that apply):  Colds  URI  Seasonal Allergies  Pollen  Exercise  Animals  Dust  Smoke  Food  Weather  Other \_\_\_\_\_  
 6. This authorization is NOT TO EXCEED 1 YEAR FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_ 7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer  Yes  No  
**FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216**

**GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated**

The Child has **ALL** of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it				

**YELLOW ZONE - GETTING WORSE**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

The Child has **ANY** of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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)				

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

CHILD'S NAME (First Middle Last)

DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

Place Stamp Here

8. PRESCRIBER'S NAME/TITLE

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIP CODE

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)  
(original signature or signature stamp only)

9b. DATE (mm/dd/yyyy)

**Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN**

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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 childcare 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 childcare program may revoke the child's authorization to self-carry/self-administer medication.

10a. PARENT/GUARDIAN SIGNATURE

10b. DATE (mm/dd/yyyy)

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. CELL PHONE #

10e. HOME PHONE #

10f. WORK PHONE #

Emergency Contact(s)

Name/Relationship

Phone Number to be used in case of Emergency

Parent/Guardian 1

Parent/Guardian 2

Emergency 1

Emergency 2

**Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM**

Child Care Responsibilities:

1. Medication named above was received Expiration date \_\_\_\_\_  
 Yes  No
2. Medication labeled as required by COMAR  
 Yes  No
3. OCC 1214 Emergency Form updated  
 Yes  No
4. OCC 1215 Health Inventory updated  
 Yes  No
5. Modified Diet/Exercise Plan  
 Yes  No  N/A
6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP  
 Yes  No  N/A
7. Staff approved to administer medication is available onsite, field trips  
 Yes  No

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

Place Child's Picture  
Here (optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. This authorization is NOT TO EXCEED 1 YEAR.

Page 1 to be completed by the Authorized Health Care Provider.

FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of plan: \_\_\_\_\_  
 Child has Allergy to \_\_\_\_\_  Ingestion/Mouth  Inhalation  Skin Contact  Sting  Other \_\_\_\_\_  
 Child has had anaphylaxis:  Yes  No  
 Child has asthma:  Yes  No (If yes, higher chance severe reaction) Child  
 may self-carry medication:  Yes  No  
 Child may self-administer medication:  Yes  No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

\*Potentially life threatening. The severity of symptoms can quickly change\*

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) Inject epinephrine right away! Note time when epinephrine was administered.
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)		DATE (mm/dd/yyyy)

Maryland State Department of Education  
Office of Child Care  
**Allergy and Anaphylaxis**  
**Medication Administration Authorization Plan**

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

PARENT/GUARDIAN AUTHORIZATION			
<p>I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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.</p>			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Card updated 4. OCC 1215 Health Inventory updated 5. Modified Diet/Exercise Plan 6. Individualized Plan: IEP/IFSP 7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

**MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure/Convulsion/Epilepsy Disorder  
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
**Page 1 is to be completed by the authorized Health Care Provider.**  
**FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216**

Place Child's  
Picture Here  
(Optional)

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Plan: \_\_\_\_\_  
 Significant Medical/Health History: \_\_\_\_\_  
 Seizure Triggers or Warning Signs: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

**Seizure Care Information**

Seizure Type	Length (duration)	Frequency	Description

**Seizure Emergency Protocol:** How to respond to a seizure (Check all that apply)

- First Aid – Stay. Safe. Side (refer to resource document “Seizure First Aid Guide”)  
 Call 911 for transport to \_\_\_\_\_  Notify parent or emergency contact  
 Notify Health Care Provider \_\_\_\_\_  Other \_\_\_\_\_  
 Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

**Care after seizure:** Does the child need to leave the classroom after a seizure?  Yes  No

What type of help is needed? (describe) \_\_\_\_\_

When can the child return to care/resume regular activity? \_\_\_\_\_

Special Considerations and Precautions (regarding activities, sports, trips, etc.) \_\_\_\_\_

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)

**MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure/Convulsion/Epilepsy Disorder  
Medication Administration Authorization Form**

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

PARENT/GUARDIAN AUTHORIZATION			
I authorize the child care staff to administer the medication as prescribed above. 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.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____ 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Form updated 4. OCC 1215 Health Inventory updated 5. Staff has received additional training to administer the medication If Yes: Trainer Name and Title _____ Date _____ 6. Staff approved to administer medication is available onsite, field trips 7. Modified Diet/Exercise Plan 8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE

## For questions, concerns or to file a complaint contact your Regional Office

Regional Offices	Phone
Anne Arundel	410-573-9522
Baltimore City	667-354-5178
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 Regional Offices investigate complaints 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 Director of Licensing at 410-767-0120.

## Resources

**Child Care Scholarship (CCS)** - Assists eligible parents and families with child care expenses  
[1-877-227-0125 money4childcare.com](http://1-877-227-0125/money4childcare.com)

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

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

**Maryland Infants and Toddlers Program** - Early intervention services for young children with developmental delays and disabilities and their families [referral.mditp.org](http://referral.mditp.org)

**Maryland Family Network** - Assists parents in locating child care [1-877-261-0060 marylandfamilynetwork.org](http://1-877-261-0060/marylandfamilynetwork.org)

**Maryland Child** - Information about child development, parenting, community resources, mental health, nutrition, literacy, and more.  
[Marylandchild.org](http://Marylandchild.org)

Maryland State Department of Education  
Division of Early Childhood  
200 West Baltimore Street  
10th Floor  
Baltimore, MD 21201

[earlychildhood.marylandpublicschools.org](http://earlychildhood.marylandpublicschools.org)

Wes Moore, Governor

Carey M. Wright, Ed.D

State Superintendent of Schools

# Parent's Guide to Regulated/ Licensed Child Care



## 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;
- Taking enforcement action when necessary; and
- Partnering with community organizations and consumers to keep all children in care safe and healthy.

Regulations governing the Maryland State Department of Education (MSDE) fall under COMAR Title 13A. Regulations that govern child care facilities and other information about the Office of Child Care may be found at:

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

## What are the types of Child Care Facilities?

**Family Child Care** – care in a provider's home for up to eight (8) children with no more than two under the age of two.

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

**Child Care Center** – non-parental care in a group setting for part of a 24 hour day.

**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;
- Must maintain certification in First Aid and CPR;
- Must maintain approved staff and student ratio and provide ACTIVE supervision all times when children are in care;
- 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?

- 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 qualified teacher 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;
- Parents/guardians may review the public portion of a licensing file; and
- Check Child Care Maryland, [CheckCCMD.org](http://CheckCCMD.org), is a resource for parents and families to use to review child care provider's license status, verified complaints, compliance history, and inspection results.