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 & 4th 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. <u>Vacation fees are only allowed for children who are enrolled in the 8 week session.</u>

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

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	**Name:**	**Name:**	☐ Yes ☐ No	**Physical Exam:**
Address:	**Address:**	**Address:**	**Child Care Scholarship**	**Dental Care:**
Phone:	**Phone:**	**Phone:**	☐ Yes ☐ No	**Specialist:**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
Printed Name and Signature of Parent/Guardian Date

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

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

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

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

3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
☐ No ☐ Yes, describe:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. Is the child on medication?
☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. Should there be any restriction of physical activity in child care?
☐ No ☐ Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)

10. **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

GUARDIAN 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													
2													
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4													
5													

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

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

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

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: _____ Date: _____

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ _____ _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ _____ _____ _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ○Male ○ Female BIRTHDATE _____ PHONE _____

PARENT OR GUARDIAN _____ _____ _____
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ○ YES ○ NO
Has this child ever lived in one of the areas listed on the back of this form? ○ YES ○ NO
Does this child have any known risks for lead exposure (see questions on reverse of form and talk with your child's health care provider if you are unsure)? ○ YES ○ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ **Signature:** _____ **Date:** _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments
	Make a selection:		
	Make a selection:		
	Make a selection:		

Comments:

Person completing form: ○ Health Care Provider/Designee OR ○ School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ○YES ○NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

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

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

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

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

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

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

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

Prince George's
20703
20710
20712
20722
20731

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

Queen Anne's
21607
21617
21620
21623
21628

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

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

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

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

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 _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR.	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated.	☐ Yes ☐ No ☐N/A
	4. OCC 1215 Health Inventory updated.	☐ Yes ☐ No ☐N/A
	5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.	☐ Yes ☐ No ☐N/A
	6. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ 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**

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)
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_____		

Section I. ASTHMA ACTION PLAN

6. **FOR ASTHMA MEDICATIONS ONLY - THIS FORM REPLACES OCC 1216. This authorization is NOT TO EXCEED 1 YEAR**	6a. FROM ____/____/_____	6b. TO ____/____/_____

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer☐ Yes ☐ No

The Child has **ALL** of these	Medication Name	Dose	Route	Frequency	Special Instructions
☐Breathing is good ☐No cough or wheeze ☐Can walk, exercise, & play ☐Can sleep all night **If known, peak flow greater than _____ (80% personal best)**					

Exercise Zone ☐CALL 911 ☐CALL PARENT ☐OTHER:_____ OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer☐ Yes ☐ No

☐Prior to all exercise/sports ☐When the child feels they need it	Rescue Medication	Dose	Route	Frequency	Special Instructions

YELLOW ZONE - GETTING WORSE ☐CALL 911 ☐CALL PARENT ☐OTHER:_____ OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer ☐ Yes ☐ No

The Child has **ANY** of these	Medication Name	Dose	Route	Frequency	Special Instructions
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest ☐Cough or cold symptoms ☐Shortness of breath ☐Other:_____ **If known, peak flow between ____and _____(50% to 79% personal best)**					

RED ZONE - MEDICAL ALERT/DANGER ☐CALL 911 ☐CALL PARENT ☐OTHER:_____ OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer ☐ Yes ☐ No

The Child has **ANY** of these	Medication Name	Dose	Route	Frequency	Special Instructions
☐Breathing hard and fast ☐Lips or fingernails are blue ☐Trouble walking or talking ☐Medicine is not helping (15-20 mins?) ☐Other:_____ **If known, peak flow below _____ (0% to 49% personal best)**					

Maryland State Department of Education
Office of Child Care

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

8. PRESCRIBER'S NAME/TITLE			Place Stamp Here
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

I request the authorized 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.

(School Age Children Only) **OK to Self-Carry** ◯ **Yes** ◯ **No** **OK to Self-Administer** ◯ **Yes** ◯ **No**

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

Child Care Responsibilities:

1. Medication named above was received	◯ Yes	◯ No	
2. Medication labeled as required by COMAR	◯ Yes	◯ No	
3. OCC 1214 Emergency Card updated	◯ Yes	◯ No	
4. OCC 1215 Health Inventory updated	◯ Yes	◯ No	
5. Modified Diet/Exercise Plan	◯ Yes	◯ No	◯ N/A
6. Individualized Plan: IEP/IFSP	◯ Yes	◯ No	◯ N/A
7. Medication Administration log attached to this form	◯ Yes	◯ No	
8. Staff approved to administer medication is available onsite, field trips	◯ Yes	◯ No	

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

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:☐ No:☐

Meals your child will receive while in care:

BK☐ LN☐ SU☐ AM Snk☐ PM Snk☐ Evng Snk☐

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

_____

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

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

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____ Date _____

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 & Worchester	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.

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

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Larry Hogan, 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

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
- 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 CheckCCMD.org.

IMPROVE CHILDREN PROGRAM

6622 Loch Raven Boulevard
Baltimore, Maryland 21239-1498
410-825-3028
Email: 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 came 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 _____

Updated May 19, 2021

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

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: _____