CROWN CARE

CROWN CARE CONTRACT

BEFORE & AFTER SCHOOL PROGRAM 2026-2027

CROWN CARE

Child's School_____

Child's Full Name_____ Birthdate_____ Age_____

Mom's Name_____Phone #_____

Mom's Email Address_____

Dad's Name_____ Phone #_____

Dad's Email Address_____

Does your child receive the Maryland Childcare Subsidy? Yes or No (Circle one)

Before School	$110/week	Signature:
Before School w/ Transportation	$135/week	Signature:
After School	$110/week	Signature:
After School w/ Transportation	$135/week	Signature:
Before & After School	$150/week	Signature:
Before & After w/ Transportation	$185/week	Signature:

Please sign beside the selected program:

A registration fee of $50/child will be charged upon receipt of this contract.

Our last day of Before & After School will be June 12, 2027.

School Days Out/Closing Policy:

* **Please check our Facebook page during inclement weather for delayed opening or closings.**
* When schools are closed for the day, Crown Care children may attend our School Days Out Camps at a discounted rate. The additional cost will be as follows:

  School Days Out Camps for child(ren) attending Before **AND** After Care: $15/full day, $10/half day

  School Days Out Camps for child(ren) attending Before **OR** After Care: $25/full day, $20/half day

Payment Policy:

* Full tuition payments are required regardless of the child's attendance. There will be no financial refund/credit of tuition including but not limited to emergency closings, weather related closings, illness, holiday closings, suspension/expulsions, unexpected withdrawals and/or family vacations.

* Tuition payments are due on the Friday before your child attends. Parents are required to participate in our Tuition Express Program through Procare which will automatically deduct the tuition from your checking account, savings account, or credit card(3% fee applied). Payments returned or rejected for uncollected and/or insufficient funds will be assessed a $35 fee, in addition to any bank charges. Uncollected payments, including fees, must be satisfied before your child may return to care.

* If early contract termination and/or a change to the contract is required, parent/guardian must complete and submit a Withdrawal/ Change Request Form to Crown Care giving 30 days advance notice. The thirty day advance notice will begin the date the Withdrawal/ Care Change request form is submitted to the Crown Care Director. If prior notice is not given prior to withdrawal, parent/guardian WILL BE RESPONSIBLE FOR THE FULL TUITION PAYMENT for the next 30 days.

* Contract will remain in effect for the entire school year, including Christmas and Easter Break. **Our last day of Before & After School will be June 12, 2027.**

* The undersigned promises to pay all costs of collections(40%), including but not limited to court costs, attorney fees(15%), of any amount due and owing.

I understand and agree to "Payment Policy" stated above. Signature_____

Date_____

Child Care Subsidy Program

If you are enrolled in the Child Care Subsidy Program and the program does not pay for the time that your child is here then you will be responsible for that payment. If your attendance is not validated or disputed causing a shortage of payment then you will be responsible for that payment. If there is a lapse in your voucher due to expiration or termination then you will be responsible for that payment. Any and all tuition payments that are not paid by Child Care Subsidy will be your responsibility to pay.

Child's Name_____

Signature of Parent/Guardian_____ Date_____

CROWN

_____ (hereinafter referred to as the/my "Child")
Child's Name

EMERGENCY TREATMENT AUTHORIZATION

I, _____, am the undersigned Parent/Guardian. I expressly acknowledge and agree by signing this Emergency Treatment Authorization (this "Authorization") I authorize the officers, directors, members, managers, Agents, representatives, employees and volunteers of Crown Center, LLC (d/b/a "Crown Care") (hereinafter "Crown Care"). To act for me (the undersigned Parent/Guardian) according to their respective best judgement in the event of a medical emergency and/or routine medical care involving the Child. By signing this Authorization, I hereby expressly waive, release and hold harmless Crown Care and all its officers, directors, members, managers, agents, representatives, employees and volunteers from any and all liability for: (a) any injury(ies), death or illness(es) sustained and/or incurred by the Child while he/she is attending any Childcare Program(s) administered or provided by Crown Care; (ii) using any facility(ides) maintained and/or managed by Crown Care., including, any facilities comprising or being a part of "Crown Center," located at 28410 Crown Road, Fruitland, MD 21826, or (iii) participating in any activity(ies) or program(s) provided, Managed or operated by Crown Care or otherwise performed or conducted at Crown Center. By my execution of this Authorization, I expressly grant permission to all officers, directors, members, managers, agents, representatives, employees and/or volunteers of Crown Care, any paramedic, or emergency services rescue squad, or any private physician and/or staff of a hospital or emergency health care facility, to provide or otherwise administer emergency medical treatment and/or routine medical care for my child, if such person(s) deem necessary. In the case of an emergency involving your Child which requires immediate attention, the Child will be taken to the nearest hospital emergency room. Your signature below authorizes a representative of Crown Care to have the Child transported to such hospital emergency room. Any such action will be taken in the best interest of the Child and will be reported to the undersigned Parent/Guardian soon as possible. By executing this Authorization, I expressly waive and release Crown Center, LLC (d/b/a "Crown Center"), and all officers, directors, members, managers, agents, representatives, employees and volunteers from any and all liability, claims, damages, and/or financial responsibility of any kind whatsoever, including, but not limited to any medical expenses incurred for medical treatment provided to the Child, which arise from any matter(s) relating to or in connection with the Child's participation or enrollment in any program(s) and/or activity(ies) managed, provided or administered by Crown Center or otherwise conducted or performed at Crown Center.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

ILLNESS

In the event the Child becomes ill during his/her participation in any Childcare Program administered or managed by Crown Care, you will be contacted by a Crown Care representative as soon as possible. If You cannot be reached, Crown will notify the Child's emergency contact regarding the Child's illness. It's your responsibility to arrange for the Child to be picked-up from the Crown Center premises as soon as possible. In the event the Child or anyone in the immediate household of the Child develops or is otherwise diagnosed with a reportable communicable disease as defined by the State Board of Health, You must notify Crown Care within 24-hours or the next business day in order for the proper action to be taken, except in the case of life- threatening diseases which You must report immediately to Crown Care.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

CROWN

_____
Child's Name

MEDICATION

Only medication prescribed by a Physician will be administered to Child. If the Child needs to take medication during Crown Care program hours, a Medication Authorization Form must be completed. The Medication Authorization Form includes space for Crown Care staff to record administration of the medicine. Do not send medications with the Child. Medicine must be provided to a Crown Care staff member by the Child's Parent/Guardian. All medicines will be kept by Crown Care staff in the designated, locked medicine box. Children are not permitted to keep medications on their person or in their book bags, lunch box, cubby, or pockets.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

ALL PRESCRIPTION MEDICATIONS SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCITONS FOR ADMINISTRATRION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. WE CANNOT ACCCEPT MEDICATION AUTHORIZATION FORMS FROM THE CHILD'S SCHOOL OR OTHER PROGRAMS-ONLY THE CROWN FORMS INCLUDED IN THIS PACKET.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

PROGRAM ENROLLMENT AGREEMENT

Carefully read and sign below:

I understand that my child will not be released to any person(s) not listed on the enrollment form. In case of an emergency, an emergency plan will be followed.

- I understand that my child will not be released to any person(s) who seem(s) to be under the influence of drugs or alcohol.
- I understand that my child must be signed in and/or out daily by myself or my designee
- If my child is experiencing problems in the program a conference will be arranged between the parent, staff and/or Program Director/Coordinator.
- Crown Care reserves the right to terminate services if it is determined the placement is unsatisfactory.
- All information provided at the time of enrollment is complete and accurate.
- False or incomplete information may lead to termination of services.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

CROWN

_____

Child's Name

PARTICIPATION WAIVER

I, understand that Crown Center, LLC (d/b/a "Crown Care") and each and every of its officers, directors, members, managers, agents, representatives, insurers, assigns, attorneys, contractors, parents, subsidiaries, successors, affiliates, principals, employees and volunteers (each a "**Releasee**", and collectively the "**Releasees**"), assumes no responsibility whatsoever for any injury or illness, of any kind, any athletic activity, sports program, child daycare program, sports class, arcade activity, Clip n Climb activity, laser tag activity, the use of any equipment or in the performance of any exercise or activity administered or provided by Crown Care or conducted at the Crown Center facilities located at 28410 Crown Road, Fruitland, Maryland 21826 (collectively the "**Released Activities**"). By my execution of this Participation Waiver, I expressly acknowledge on behalf of myself, my spouse, the Child and all of my successors, heirs, representatives and assigns (collectively the "**Releasors**"), that I assume all risk for any and all injuries and illness which may be sustained or otherwise suffered by the Child arising from which may result from his/her participation in any of the Released Activities and, furthermore, I hereby release and discharge the Releasees from any and all claims of injury, illness, death, loss or damage which my child my suffer or sustain as a result of his/her participation in any of the Released Activities. I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS EACH AND EVERY OF THE RELEASEES FROM ANY AND ALL LIABILITY, CLAIMS, DEMANDS, LOSSES AND/OR DAMAGES SUFFERED BY OR ON ACCOUNT OF MY CHILD WHICH MAY BE CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE ACTS OR OMMISSIONS OF ANY RELEASEE(S), INCLUDING ANY RESCUE OPERATION(S) CONDUCTED, OVERSEEN OR MANAGED BY ANY RELEASEE(S), REGARDLESS OF NEGLIGENCE OR THEABSENCE THEREOF ON TH EPART OF ANY RELEASEE. I FURTHER EXPRESSLY ACKNOWLEDGE AND AGREE: IF, DESPITE THIS RELEASE AND THE TERMS OF THE AGREEMENT SET FORTH HEREINABOVE, THE CHILD (AS IDENTIFIED ABOVE), OR ANY PERSON(S) ACTING ON BEHALF OF SUCH CHILD, MAKES A CLAIM AGAINST ANY RELEASEE(S), I, AT MY SOLE COST AND EXPENSE, SHALL INDEMNIFY, SAVE AND HOLD HARMLESS EACH AND EVERY OF THE RELEASEES FROM ANY AND ALL LITIGATION EXPENSES, ATTORNEY FEES, LOSS, LIABILITY, DAMAGE, OR COST ANY RELEASEE(S) MAY INCUR AS A RESULT OF ANY SUCH CLAIM. I EXPRESSLY ACKNOWLEDGE AND AGREE THE CHILD IDENTIFIED HEREIN ABOVE SHALL BE DEEMED AND OTHERWISE CONSTRUED TO CONSTITUTE A "RELEASOR" OF THE RELEASEES; NOT WITHSTANDING ANY TERM TO THE CONTRARY SET FORTH IN THIS "PARTICIPATION WAIVER,"

IN THE EVENT OF ANY CONFLICT BETWEEN THE TERMS OF THIS "PARTICIPATION WAIVER" AND ANY OF THE TERMS CONTAINED ELSEWHERE IN THIS CROWN CARE REGISTRATION PACKET, THER TERMS CONTAINED IN THIS PARTICIPATION WAIVER SHALL GOVERN THE UNDERSIGNED MINOR'S PARENT AND/OR LEGAL GUARDIAN, THE CHILD IDENTIFIED HEREINABOVE, AND ALL RELEASEES (AS DEFINED HEREINABOVE) WITH RESPECT TO ANY AND ALL MATTERS REFERENCED IN THIS PARTICIPATION WAIVER. I recognize that Crown care will make every reasonable effort to minimize exposure to known risks associated with the Childcare Program(s) managed and provided by Crown Care. I understand that whether Crown Care is not, nor is any other Releasee, responsible for any personal property which becomes lost, stolen, or destroyed while Childcare Program participants are using the Crown Center facilities. I hereby expressly permit and authorize Crown Care to use, without limitation or obligation, photographs and/or film footage of my child's image or voice for purpose of promoting or interpreting Crown Care programs. BY MY EXECUTION OF THIS PARTICIPATION WAIVER, I, ON HEHALF OF MYSELF AND ALL RELEASORS, EXPRESSLY ACKNOWLEDGE AND AGREE: I HAVE READ THIS PARTICIPATION WAIVER, I FULLY UNDERSTAND ALL TERMS CONTAINED HEREIN, I FULLY UNDERSTAND THAT I, ON BEHALF OF MYSELF AND ALL REALSORS, HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING THIS PARTICIPATION WAIVER, AND I HAVE SIGNED THIS PARTICIPATION WAIVER FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE, AND I INTEND THIS PARTICIPATION WAIVER TO BE A COMPLETE AND UNCONDITIONAL RELAEASE OF THE REALEASEES OF AND FROM ANY AND ALL LIABILITY OF ANY KIND WHATSOEVER, TO THE GREATEST EXTENT ALLOWED BY LAW.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

PRINTED NAME OF PARENT/GUARDIAN _____ **DATE**_____

CROWN

_____
Child's Name

REGULARLY SCHEDULED OUTINGS

PERMISSION SLIP

My Child _____ has my permission to participate in the activities listed below transported by Crown Center, LLC (d/b/a "Crown Care") staff to the following activities and places:

1. Arcade located inside of Crown Sports Center
2. Clip n Climb located inside of Crown Sports Center
3. Laser Tag Arena inside of Crown Sports Center
4. Crown Room located inside of Crown Sports Center
5. Outdoor sport fields located at the North end of Crown Sports Center
6. Outdoor woods located at North of the outdoor fields
7. All indoor fields and sports court

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

PERMISSION TO TRANSPORT FORM

I (Parent/Guardian Printed Name) _____ authorize Crown Center, LLC (d/b/a "Crown Care") to transport my child (Child's Name) _____ to and from (Name of Child's School) _____ as well as field trips, special events and in the event of any emergency, weather or biohazard etc., that may occur during the 2026-2027 school year.

Parent Signature: _____ **Date:** _____

Parent Printed Name: _____

CROWN

_____
Child's Name

ENROLLMENT MEDICAL NEEDS

Does your child have any health concerns such as:

Allergies	YES	NO	Medication required _____
Asthma	YES	NO	Medication required _____
Diabetes	YES	NO	Medication required _____
Seizures	YES	NO	Medication required _____
Other	_____		Medication required _____

If you have circled YES to any of these concerns, you will need to complete an action plan. You may obtain the form from our website, office, or health packet.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE**_____

SUNSCREEN and INSECT REPELLENT POLICY

Parent Permission Form

Camp Crown does not provide sunscreen or insect repellent for participants.

- Sunscreen/insect repellent should be applied in the morning before your child arrives at Camp Crown.
- Sunscreen/insect repellent should be in the original container only.
- Sunscreen/insect repellent must be clearly labeled with the child's name.
- Sunscreen/insect repellent will be stored in camper's classroom.
- Please make sure the sunscreen/insect repellent you provide has been used previously on your child with no adverse reactions.
- School age students will reapply their own sunscreen before outdoor activities, if needed.
- If your child should require assistance applying sunscreen/insect repellent, you must give permission below.
- Please make sure that you purchase clear spray sunscreen.
- Under No Circumstances are campers allowed to apply sunscreen/ insect repellent to another camper.

☐ I authorize the staff at Camp Crown/Crown Center, LLC to apply sunscreen/insect repellent to my child.

☐ Do not apply sunscreen/insect repellent to my child. This means that you do not want counselors to help with the application of sunscreen.

Signature of Parent/Guardian _____ **Date** _____

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 _____

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete*

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

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 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 DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1													
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: _____

How To Use This Form

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

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

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

How To Use This Form

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

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

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

Frequently Asked Questions

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

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

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

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

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

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

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

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

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

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

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

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

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

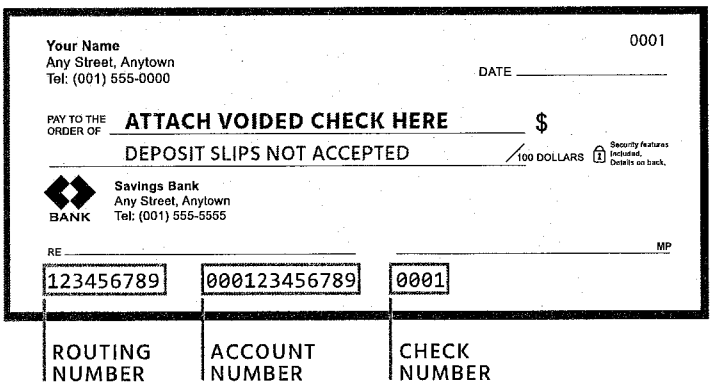
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



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Date Received

Employee Signature

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