

About Your Child

1. What FOODS does your child especially like? _____

2. Especially DISLIKE? _____

3. Favorite toys, games, activities? _____

4. Is your child TOILET TRAINED? _____ What words does your child use for toilet? _____

5. How does your child express ANGER or frustration? _____

6. Does your child have any special FEARS? _____

Explain _____

7. When your child is upset, what helps to COMFORT him/her? _____

8. How do you DISCIPLINE your child? _____

9. Has your child been taking an afternoon NAP? _____ If so, how long? _____

If not, why? _____

10. Special toy or blanket for NAP? _____

11. Special FAMILY situations? (*such as custody specifications, problems arising from situations, etc.*) _____

12. Anticipated ADJUSTMENT problems? _____

13. Any disorders/developmental (slow, advanced) diagnosed or suspected? _____

14. Previous childcare child has attended: _____

15. Any problems at previous daycares? _____

16. EXPECTATIONS of Day Care Home _____

17. Other COMMENTS? _____

Learning Station Childcare provider assisted potty training.

If you feel your little one is ready, I would like to share with you some ideas and experiences to help the process. We have some basic policies when the time comes to begin training. I've put in bold the most important points. This may sound awfully official but, honestly, this can assist with smooth potty training.

A potty-trained child is a child who does the following:

- 1) Be able to TELL the adult they have to go potty BEFORE releasing on themselves.
- 2) Be able to pull down their underwear and bottoms ~~pants~~ and pull them back up without minimal assistance.
- 3) Be able to wipe themselves after using the toilet.
- 4) Be able to get off the potty by themselves.
- 5) Be able to wash and dry hands.
- 6) Be able to go directly back to the room without directions.
- 7) Be able to postpone going if they must wait for the bathroom to become available or if we are outside away from the house.

The first one is the number one key to successful training. Children who are ready to train have the ability to perceive events that are going to happen before they happen. Because we cannot allow children to just go in and out of the room to freely use the potty, they MUST learn to notify a staff member so that we may accompany them into the room and supervise them. At home you can allow them free access to the bathroom if you choose, but we are prohibited by our regulations to allow them to go unaccompanied. Because of this, they need to learn that they must tell the adult they have to go as soon as possible. We do not accept signs that the child has to go or nonverbal behavior. It must be the words "I have to go potty".

Is your child ready to begin training?

Sometimes, parents feel that if their child is able to actually pee on a potty at home when the parent places them on the potty that this is the sign they are ready to train. From my experience, this is not necessarily a sign. I have seen many children who are able to do this who actually trained more than a year after they were able to do this. I always say that potty training is five percent ability to get their clothes on and off, five percent ability to go pee or poop in the potty and NINETY percent being able to identify when they have to go and telling the adult BEFORE it's too late.

Some things we do to get kids ready to train:

- 1) We have them sit on the potty during natural transition times (before and after meals, before and after naps, and diaper changes)
- 2) We practice with them getting their pants up and down on their own and hand washing.
- 3) We will supervise them and watch for signs that they have to go or are going and get them off to the potty.
- 4) We keep close communication with the parents about any indicators suggesting the child is ready.

Some things we don't do:

We do not put kids on a potty schedule where they go every half hour or hour. It's very time consuming with little to no benefit. From experience, we have seen this cause many problems with children not being able to hold much urine and having to constantly go to the potty further along down the line. We don't limit food or drinks to only be given at certain times. We maintain the same food and snack schedule during training.

We don't clean out poopy underwear. We will bag urine soaked underwear and return it to the parent at the end of the day, but we will not do this with soiled underwear. We must dispose of that immediately into the garbage. We don't do laundry of any soaked or soiled clothes. They are bagged, put outside, and returned to the parents at the end of the day.

Some helpful hints to help you at home:

There are some easy daily things you can do at home that will really help your child's progression. Some of these may sound silly but they REALLY work.

- 1) Be cheery about the potty. A happy experience each time they are on the potty will translate into quick training at home.
- 2) If there are two adults in the house have each adult "ask" the other adult if he/she can go to the potty at least four or five times a day. Your child seeing and hearing you "ask" if you can go will get the idea in their head that they need to do that too.
- 3) Praise the child on success for every step of the process but do not overdo it. You don't want them trying to do the potty thing fifty times a day to get your attention or get rewarded. A "way to go" or a "thumbs up" and big smile will let them know you are proud.
- 4) Bribery can be a good thing. Use stickers or small treats (like gummies, jelly beans, teddy grahams) ONLY after potty success. Have the child give the same treat to everyone around him that can have the treat. Passing a treat for his success will make the child happier than getting the treat himself. Every person receiving the prize says "Good job"
- 5) Let the child in the bathroom with you when you are going potty. Let them see how it works and you washing up afterwards.
- 6) Don't let them play with toilet paper. If they are infatuated with toilet paper, consider giving them an inexpensive roll to play around with in the house to get it out of their system.
- 7) No punishment for accidents. Just talk to them about them needing to ask to go to the potty next time.
- 8) If you see them mid-way trying to poop or pee, scurry them off to the potty to finish up.
- 9) Give your child three or four minutes to get the job done. It shouldn't take more than a few minutes. Don't let it turn into an attention seeking time. It's only about going potty. If they don't go in a reasonable time tell them it's time to get off and we will try again another time.
- 10) Don't allow potty time to be a stall tactic to avoid doing something the child doesn't want to do.
- 11) I don't encourage any toys or books during the training time.
- 12) Keep attention and interaction during potty time to a bare minimum. Keep the atmosphere calm and focused.
- 13) We train boys sitting down first. We switch them to standing up when they are tall enough to reach over the seat and adept enough to aim.
- 15) Have fun. Stay cool. It will all work out.

Please don't expect the same performance here as at home:

Kids are not trained at home to tell the parents they have to go BEFORE it's too late, but rather are allowed free access unsupervised to the bathroom in their home. Again, here they must tell us BEFORE. They can't leave the playroom without an adult and go into the bathroom without supervision.

- 1) There are many more distractions here with a larger group of kids, toys, and bustling activities.
- 2) They need one to one attention throughout the day in order to keep up with toiletting. Here we have multi-level aged children who have various needs and supervision requirements. We must divide our attention with all the kids.
- 4) Parents are putting the child on the potty in small time increments. We don't do this here so the child will wet themselves many times throughout the day if this is being done at home.
- 5) There is also an element of the parent population who believe that early training is a sign of giftedness and want their children to be advanced. Potty training has nothing to do with giftedness, regardless of the age of training.

We have also had kids who are successful here but will not do it at home. This can happen if:

- 1) The child is on the go a lot in the evenings and weekends making it difficult for the parent to do toiletting practice at home.
- 2) Children are with different caregivers on the weekend who don't continue the practicing.
- 3) Parents want the training to be done at day care during the day and do diapers and pull-ups at home on the weekends.

We don't put children into underwear until they have been COMPLETELY accident free HERE for two full weeks.

Naptime training:

Sometimes kids nap train right away when they are awake time trained. Most children are not able to do this and it is many months and sometimes years before they are nap trained. We require nap diapers until the child has slept through nap for one full month without a pee accident.

What to wear during training:

Children should wear easy on and off pants during training. We prefer sweat pant like bottoms until they are physically capable of doing snaps and buttons. Please don't send them in anything that requires us to remove the top to get to the bottom. We don't allow overalls, kid costumes, one piece jammies, or shirts with snaps at the crotch. Belts and suspenders are never allowed in the day care for safety reasons.

Diapers and pull-ups are okay for training. We do not use pull-ups until the child is at the one week mark without accidents. We do not do cloth diapers or underwear with plastic pants. If you have had great success at home we can do the training with the underwear and a pull-up over the underwear during the training. If the child has regular accidents in their underwear, we will switch them back to regular diapers and try again at another time. We use regular diapers at nap time.

Finally, I have found that a number of kids are easily potty trained during long vacations and holiday breaks. The parents have the time to do the intense work and supervision. Parents can allow the child to be in underwear for many consecutive days. If they are successful at home they still must remain in diapers and be accident free for two weeks HERE. They can come in underwear with pull-ups when they return. That way they will have a protective layer over the underwear to protect clothing should they revert back to accidents. I will provide individual toiletting progress daily.

Parent Signature _____ Date _____

Maryland State Department of Education
Office of Child Care
ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

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	DATE	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)	
Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER					
4. ASTHMA SEVERITY: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced ☐ Peak Flow Test ____%					
5. ASTHMA TRIGGERS (check all that apply): ☐ Colds ☐ URI ☐ Seasonal Allergies ☐ Pollen ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other _____					
6. This authorization is NOT TO EXCEED 1 YEAR FROM ____/____/____ TO ____/____/____ FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216					
7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No					
GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated					
The Child has <u>ALL</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency
☐ 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: _____					
☐ Prior to all exercise/sports ☐ When the child feels they need it		Medication Name & Strength	Dose	Route	Time & Frequency
					Special Instructions
YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER: _____					
The Child has <u>ANY</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency
☐ 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: _____					
The Child has <u>ANY</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency
☐ 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)					Special Instructions

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

OCC 1216 A REVISED SEPTEMBER 2022 – all previous editions are obsolete PLEASE TURN OVER – THIS FORM HAS 2 SIDES WITH 4 TOTAL SECTIONS

PHOTO & VIDEO RELEASE FORM

As the parent of a child/children enrolled at _____

(Child care center name or provider's full name)

I understand that my child(ren) whose name(s) are listed below may be photographed or recorded during child care hours, field trips, or activities. I understand that these photographs may be used for classroom projects or in promoting child care services either in print (newspaper, flyer, etc.), TV, or on the Internet including but not limited to the CareLuLu website (www.CareLuLu.com), social media pages, and our own child care website.

(Please mark the appropriate box)

☐ I give permission

☐ I do NOT give permission

for my child(ren) to be photographed or recorded and for the photos or videos to be used as described above.

(Please write each child's full name)

1. Child's first and last name _____

2. Child's first and last name _____

I understand that it is my responsibility to update this form if I no longer wish to authorize the above uses. I also agree to forego any right or entitlement to any compensation or fees. Finally, I confirm that I am the legal guardian of the above-named child(ren).

First and Last Name (Parent 1)

Email Address

Cell Phone

First and Last Name (Parent 2)

Email Address

Cell Phone

Date

Parent's Signature

**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)
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Maryland State Department of Education

Office of Child Care

MEDICATION ADMINISTRATION LOG

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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

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
_____ Last _____ First _____ Middle			_____ Mo / Day / Yr		M ☐ F ☐
Address:					
_____ Number _____ Street		_____ Apt#	_____ City		_____ State _____ Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W: _____	C: _____	H: _____	
		W: _____	C: _____	H: _____	
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: _____			Birth Date: _____		Sex M ☐ F ☐	
Last	First	Middle	Month / Day / Year			
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
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:

CACFP Enrollment: Yes: ☐ No: ☐

EMERGENCY FORM

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

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

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	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4								
5	DOSE #5												

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

1.

Signature Title Date

(Medical provider, local health department official, school official, or child care provider only)

2.

Signature Title Date

3.

Signature Title Date

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

Clinic / Office Name

Office Address/ Phone Number

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

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

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)

FIELD TRIP PERMISSION

Date _____

I/We hereby give **Learning Station Childcare** permission to take my/our child _____

off the premises and on excursions that will take place during regular childcare

hours. I understand that I will be notified of any such trips beforehand, that trips

will be supervised and that all precautions will be made for the safety and well

being of all the children. I/We also understand that **Learning Station Childcare** will not be liable for any accident or injury.

Consent is for normal activities unless indicated below ~ the following activities

may occur during the course of the day at Learning Station Childcare.

Please initial those activities your child has permission to participate in:

_____ Go for walks

_____ Ride a bike

_____ Go to a park

_____ Ride in wagon/stroller

_____ Go on field trips(transportation will be provided if required. If there is an additional fee for any field trip you will be notified in advance)

Are there any other activities in which your child should not participate? _____

Mother's Signature _____

Father's Signature _____

Emergency Transportation and Treatment Authorization

Fill out either section 1 or 2 below. DO NOT fill out both.

1. Permission to Transport and Secure Treatment:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I grant my permission for:

(Name of childcare provider)

To take my child:

(Name of child)

To the nearest hospital or medical/dental facility for treatment for any accident or illness that provider feels needs immediate medical attention. I accept liability for all expenses incurred.

Signature:

(Signature of parent/guardian, and date)

2. Refusal to Grant Permission:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I **DO NOT** grant my permission for:

(Name of childcare provider)

To take my child:

(Name of child)

To the nearest hospital or medical/dental facility for treatment for any accident or illness that provider feels needs immediate medical attention.

Instead, I wish the following action to be taken:

Signature:

(Signature of parent/guardian, and date)

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

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>

ACTIVITY AUTHORIZATION FORM

I hereby grant permission for my child, _____

To use all of the play equipment and participate in all of the activities at (Learning Station Childcare)

The following restriction excepted:

I understand that ride on toys, teeter totter, slide, large climber, chairs, wading pools, sprinklers, sandboxes and other toys are used on a regular basis.

I also understand that helmets, and knee and elbow pads will not be provided by the caregiver but are encouraged to be provided by the parent for activities such as bike riding, rollerblading, skateboarding, tobogganing, etc.

I will not hold the caregiver responsible for injuries incurred while using equipment at the daycare home, providing the children are supervised and the equipment is in good repair.

Comments or Concerns noted:

Parent's Signature: _____

Parent's Signature: _____

Date: _____

Discipline Policy

We encourage positive redirection by showing children what we would like them to do. An example would be two fighting over the same toy. I would recommend that the children take turns playing with the toy and offer another toy to play with until it is your turn. We replace the negative behavior with positive behavior. Positive discipline teaches children where limits are set, how to maintain control of their bodies, and how-to problem solve in the event of the conflict. Children are given verbal rules and expectations daily. Because we instill the core values daily, all children are given the opportunity to do make the choice to do what is right and acceptable.

We encourage children to empathize with one another's feelings and see the results of their actions. We discourage inappropriate behavior. We use "The reflection chair" as our last resort. Any child that is put in the reflection chair is always supervised by a teacher and shall remain in time out only 1 minute per age of the child. When time out is over, it is explained to the child why time out occurred and what correct behavior is expected. No child is subjected to corporal punishment or physical discipline at any time. **Discipline shall never be related to or include;**

- * profanity, negative remarks about a child or his family, or other verbal abuse.
- * humiliate, shame or frighten a child.
- * spanking, hitting, striking, biting or pinching.
- * No child shall be confined in an enclosed area, such as a locked room, box or closet.
- * preventing a child from eating, sleeping, using the toilet or other cruel, harsh, or unusual punishment
- * No child shall be allowed to discipline another child.

We will make every effort to work with parents of children having difficulties in child care. However, children displaying chronic disruptive behavior which is upsetting to the physical or emotional wellbeing of another child may require the following actions:

1. Parents of the child will be called in for a conference. We will discuss the issues and identify some possible solutions. A plan of action will be developed and agreed upon by the parents, staff, and a health/behavioral specialist.
2. If the plan of action is not working, the parents will be called in for another meeting. We will discuss what is not working and develop another action plan.
3. If no progress has been made towards solving the problematic behavior, the child may be suspended from care. This suspension may range in length from the rest of the day to indefinitely.

Learning Station Child Care reserves the right to cancel the enrollment of a child for the following reasons:

- Physical and/or verbal abuse of staff or children by parent or child
- Not observing the rules of the center as outlined in the handbook and/or parental agreement

The use of physical force as a discipline measure is prohibited. This includes spanking, slapping, pinching, shaking, biting, pulling hair or arms, jerking, etc. A discipline policy is provided to parents.

Parent Signature _____ Date _____

Parent Signature _____ Date _____