



## Before & After School Enrichment

Dear Y Families,

Thank you for enrolling your child in the largest provider of licensed quality Before & After School Enrichment (BASE) in Maryland. At the Y of Central Maryland, we've designed our programs to include all the things parents feel are most important -- ample amounts of love, attention, fun, games, homework help, healthy snacks and engaging activities in clean, safe environments where kids have lots of choices, can make new friends and discover what they love!

We're excited to offer **for the 2015-2016 school year, our NEW complimentary Y Family Membership included with all full-time (5 days a week) enrollments!** This is a great opportunity to engage in healthy family fun at all 12 Family Center Ys! Please see the enclosed flyer for more information about this exciting new full-time participant benefit!

To finalize your registration, all families must complete the attached forms and return them via fax or email no later than August 14, 2015 for the start of the school year. *Children's files must be complete for program attendance.* **Parents should submit completed paperwork to the Y Customer Billing office via fax at 410-779-9426 or email to [billing@ymaryland.org](mailto:billing@ymaryland.org).**

- ☐ Registration Agreement
- ☐ EFT Form (must be renewed annually)
- ☐ Enrollment & Liability Release/ Medication Information Form
- ☐ Emergency Care Plan
- ☐ Health Inventory Parts I & II
- ☐ Immunization Certificates
- ☐ Guide to Regulated Child Care
- ☐ Emergency Contact Form
- ☐ Medication Administration Authorization Form
- ☐ Asthma Action Plan (if applicable)
- ☐ Allergy Action Plan (if applicable)

Tuition payments are due monthly starting August 1st ending May 1st. The Y offers several payment options including credit card EFT, online payments, walk-in to centers, over-the phone credit card payment, and check by mail.

Please look for additional information on School's Out Days and other programs, and the Parent Handbook at your child's site. Should you have any additional questions, please feel free to contact Customer Billing at 443-322-8000 option #1 or visit us on the web at [www.ymaryland.org](http://www.ymaryland.org).

Thank you again. We look forward to a great school year!

Sincerely,

Derryck D. Fletcher  
Vice President of Youth Development

# NEW FOR 2015/2016 Y BEFORE & AFTER SCHOOL ENRICHMENT

## All Full-time Participants Receive a Complimentary Y Family Membership *Included* with Enrollment!



### Get Ready to Go to Your Happy Place!

- Complimentary family membership good at all 12 Family Center Ys for the 2015/2016 school year (valued at over \$800)!
- Enjoy full Y member benefits including free exercise classes like Zumba, yoga, cycle and others; free activities like Funshops for kids, rockwall climbing, lap swim, family swim and more; free monthly events like movie nights and BBQs; all under one roof at the Y!
- Save on Y programs like swim lessons, youth sports and martial arts!
- Complimentary family membership valid Sept. 1, 2015 through Jun. 15, 2016. Extend your membership over the summer months with our Summer Bridge Membership and save on Y Camp too!

### How to Get Started

- Register full-time for the 2015/2016 Y Before & After School Enrichment program.
- Bring your approved registration form to any Family Center Y to redeem your complimentary family membership.

For more information on activating your complimentary family membership, the summer bridge membership for the 2016 camp season, or any other questions, please contact your Site Director or the Y Customer Billing office at 443-322-8000 or [billing@ymaryland.org](mailto:billing@ymaryland.org). **SEE YOU AT THE Y!**



**Before & After  
School Enrichment**  
Y of Central Maryland  
It's deeper here.

Find a Y near you  
at [ymaryland.org](http://ymaryland.org)



## Before & After School Enrichment – School Year 2015-2016 PROGRAM REGISTRATION FORM: Monarch Global Academy

Child's Name  DOB  Grade (entering Fall 2015)  Gender

Home Address  City  State  Zip

\*Primary Parent /Guardian Name  Cell Phone  Work phone

Address (if different from child's)

Parent/Guardian Name  Cell Phone  Work phone

Address (if different from child's)

\*Primary email address:  Primary phone number:

\*Please note that Primary Parent list above will receive all emails, tax information, and family membership details.

Race (optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino  
☐ Native Hawaiian/Other Pacific Islander ☐ Two or more races ☐ White/Caucasian ☐ Other  
Household Income (optional): ☐ \$0-\$19,999 ☐ \$20,000-\$39,999 ☐ \$40,000-\$74,999 ☐ \$75,000-\$99,999 ☐ \$100,000+  
How did you hear about the Y? ☐ School ☐ Family Center Y ☐ Friend ☐ Email ☐ Web ☐ Other

**Hours of Operation:** All Sites Before School Enrichment open at 6:00 a.m. After School Enrichment ends at 6:00 p.m.

**School Sites** (please select): ☐ Monarch Global Academy

**Start date requested:**  (Child's start date is subject to change based on acceptance of payment/required paperwork)

**Enrichment needed** (please Select): ☐ Full Time (5 days) ☐ Part Time (3 days) Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

**Registration Fee:** \$60.00 (Registration fee is non-refundable and non-transferrable. Fee is due at time of registration.)

**Monthly Rates:** (please select)

	Before & After School Enrichment	After School Enrichment Only	Before School Enrichment Only
Full Time: <input type="checkbox"/>	\$363	<input type="checkbox"/> \$238	<input type="checkbox"/> \$150
Part Time: <input type="checkbox"/>	\$293	<input type="checkbox"/> \$193	<input type="checkbox"/> \$122

A 10% sibling discount is also available, subject to restrictions. First payment is due August 1 and last payment is due by May 1. A \$25.00 late fee is assessed after the 5<sup>th</sup> of each month. All cancellations and changes to enrichment must be submitted in writing two weeks before the requested cancellation/change date along with a brief explanation and parent/guardian signature to the Customer Billing Office.

**Financial Assistance:** Available on a sliding scale to those who would otherwise be unable to participate. DSS vouchers are also accepted.

**Schools Out Day Programming:** When schools are out for teacher meetings, holidays, or inclement weather, and based on site availability, we will attempt to provide a full day of theme activities which may have additional fees. Space is limited. A fee will be assessed for those that register for School's Out Days, but do not attend as scheduled. Contact Customer Billing for details on School's Out Days costs. **Professional In-Service days are included in Full Time Before & After School Enrichment participant's tuition payment.**

**Emergency and Medical Information:** I acknowledge that I must have my child's completed emergency and medical forms on file prior to my child's first day. If forms aren't current and on file, I understand that my child will not be permitted to start care.

**Registration Payment:** (please select)

- ☐ I would like my EFT account ran for registration fee payment. (2015-2016 EFT form is attached in packet)  
☐ After August 1<sup>st</sup>, please run EFT for 1<sup>st</sup> month's tuition payment.  
☐ I will call into Customer Billing (443-322-8000) at my earliest convenience to make payment.

I have read and understand the Y's payment schedule and policy (Initial) .

I understand my child is not fully registered for enrichment programming until I make payment on the account and receive a confirmation email from Billing. (Initial) .

My signature, or electronic signature, below gives permission to enroll my child in the Y's Before and After School Enrichment program.

Parent/Guardian printed name  Date



Y of Central Maryland  
It's deeper here.®

## Membership Registration Form Before & After School Enrichment

FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

**Start Date: September 1<sup>st</sup> 2015-End Date: June 15<sup>th</sup> 2016**

Please select type: ☐ Full Time Before & After, ☐ Full Time After Only ☐ Full Time Before Only.

### PRIMARY PARENT MEMBERSHIP INFORMATION

Name of Primary Parent\*

Gender

DOB

Email Address

Phone Number

\*Please make sure the primary Adult on the membership is the primary parent listed on the Before & After School Registration form. The primary parent receives all Before & After School Enrichment information, billing receipts, tax information, and membership notification and information.

### ADDITIONAL ADULT MEMBER INFORMATION

(Family Membership can have up to 4 adults residing in the same Household)

FULL NAME

Gender

DOB

FULL NAME

Gender

DOB

FULL NAME

Gender

DOB

### DEPENDENT INFORMATION

Full Name

Gender

DOB

Full Name

Gender

DOB

Full Name

Gender

DOB

Full Name

Gender

DOB

**Instructions for activating your Y Family Membership:** Please bring a copy of this form and your Before & After School Enrichment registration form to your select primary family center to activate your membership. Please note Before & After School Families will be asked to have a photo taken and receive their access cards prior to using the family centers.

### PRIMARY Y FAMILY CENTER LOCATION FOR MEMBERSHIP

(Please select one primary Family Center)

☐ Catonsville Family Center

☐ Druid Hill Family Center

☐ Harry & Jeanette Weinberg Family Center (Baltimore City)

☐ Parkville Family Center

☐ Orokawa Family Center (Towson)

☐ Y Swim Center at Dundalk

☐ Dancel Family Center (Ellicott City)

☐ Greater Annapolis Family Center (Arnold)

☐ Hill Family Center (Westminster)

☐ Perry Hall Family Center

☐ Walter & Betty Ward Family Center (Abingdon)

☐ Y Swim Center at Randallstown

**Policy Notes:** Please note, if you cancel your Y Before & After School Enrichment full-time enrollment, your complimentary membership will be cancelled and the standard monthly family membership rate will be applied to your account.

**WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT:** In consideration for use of the YMCA facilities and participation in YMCA programs, I understand that the Y of Central Maryland assumes no responsibility for injuries or illnesses which I (or my dependents) may sustain as a result of my physical condition or resulting from participation in any athletic activities, sports program, the use of any equipment, exercises or other activities. I expressly acknowledge on behalf of myself and my heirs that I assume the risk for any and all injuries and illnesses which may result from participation in these activities. I hereby release and discharge the Y of Central Maryland, its agents, assigns and/or employees from any and all claims for injury, illness, death, loss or damage which may result from my participation in these activities. I understand that the Y of Central Maryland is not responsible for personal property lost or stolen while members and/or program participants are using Y facilities or on Y premises.

**I HAVE READ AND AGREE TO THE ABOVE WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT**

Signature of Primary Member/Parent Guardian (if under 18)

Date



**Registration Agreement**

Please review the information listed below to ensure that you understand your responsibilities and agreements in enrolling your child in the Y Before and After School Enrichment Program.

**Demographic Information**

The Y receives financial grants, gifts, and donations from public and private sources. Many of these sources require us to provide an overview of the customers and communities we serve such as age, grade, sex, and number of children by school or community, as well as race and household income. Specific and individual information about you or your family is never isolated and shared. This information is helpful, but optional. Please see the BASE Program Registration Form for details.

**Tuition**

Tuition is billed monthly and in advance of services received. Tuition is calculated by taking the yearly program fees that cover the days that school is in session and dividing that into 10 equal monthly payments beginning August 1, 2014 or at time of registration and ending May 1, 2015. Tuition

prices are subject to change.  (Initial)

**Monthly Tuition Payments**

Payment is due on the 1st of each month. A \$25.00 late fee is applied after the 5th of the month for any account with an outstanding balance. If payment is not received by the 8th of the month, then the child will be unable to attend the program until the balance is paid in full. Payments not received by the 15th of the month will result in termination. We may then contact our waitlist for openings. Re-enrollment, should there be space, will require the balance to be paid in full and a new registration fee to be paid in full. Note: late fees are assessed based on date payment is received by

customer billing office, not by postmark date. A payment schedule has been provided for your reference.  (Initial)

**Payment Options**

All payments must be received by mailing a check to the Customer Billing Office, or credit payment over the phone or online. Site and/or center directors are not allowed to collect monthly payments. The Y of Central Maryland accepts money order, American Express, Discover, MasterCard & Visa credit cards, and Electronic Fund Transfers (EFT). The Y will also gladly accept your personal check; however, there will be a \$25 charge for any

check returned to us unpaid by your bank.  (Initial)

**Financial Assistance**

The Y of Central Maryland accepts DSS and other third party payment arrangements that may be able to assist you. We also have a Financial

Scholarship program to assist families in need. Applications are available through the Customer Billing Office.  (Initial)

**Changes in Program Enrollment**

All enrollment changes must be made in written form and sent to the Customer Billing Office, two (2) weeks prior to the change. Site/center directors cannot accept verbal notification of changes or withdrawals. Parents are responsible for contractual payments. There is a \$10 processing fee for refunds and changes in care. Registration fees are neither refundable nor transferable. Snow days, School's out Day and have separate

cancellation and credit/refund policies.  (Initial)

**Absentee and Sick Child**

There will be no reduction of fees if a child is absent from the program, including illness. The Health Department's regulations concerning

periods of infection will be enforced.  (Initial)

**Closings and Early Dismissals**

There will be no reduction of fees for holiday closings, emergency closings, or if the site is forced to close due to circumstances beyond the Y's control (i.e. water main break, power outage, severe/inclement weather, etc). For sites located within the school system . . . the Y is unable to run programming on emergency early dismissal days. Programs or half-days, and extra days of programming may require advance registration and may

have additional fees and separate credit/refund policies.  (Initial)

**In-Service Days/School's Out Day**

A variety of options will be made available for days when school has planned time off. A schedule of activities, registration procedures, and fees will be made available prior to these days. Please note that these days are beyond the planned school days as covered by the before and after enrichment tuition and some additional fees may apply. Payment and registration forms are due within 5 days of the date of service. Late payment fees and

suspensions for non-payment may apply.  (Initial)

**Custody Issues**

If there are any custody issues, the parent will provide a court order indicating who is the custodial parent/guardian and the names of anyone in which the staff should NOT release the child. It should be noted that there is one account for each family. If the account is outstanding, regardless of whose responsibility it is to make payment, then care may be suspended or terminated. We require parents to communicate with each other and that they

refrain from placing our staff in the middle of any custody issues. Failure to do so could result in immediate termination.  (Initial)

**Sign-In and Sign-Out**

Children must be accompanied into and out of the program space by a parent or an authorized adult (at least 18 years of age) at all times. An

authorized adult must sign the in/out roster and present photo ID to ensure that this safety regulation is enforced.  (Initial)

**Late Pick-up**

The BASE program closes promptly at 6:00pm (school sites) and 6:30pm (preschool locations). Parents are considered late if the child has not been picked up by the times listed above (regardless of the reason). Any parent arriving late will be charged a late fee of \$5 per child for every five minute increment or fraction thereof. There is no cut-off time for this fee and the authorities will be notified for any children remaining past 7:00pm. Repeated lateness could cause dismissal from the program. Payment is due within 24 hours of date of late pick-up – late payment fees and suspensions for non-

payment may apply.  (Initial)

**Forms and Account Information**

It is the parent/guardian's responsibility to notify the staff of any medical information pertinent to their child's health, safety and well-being; and to provide updated medical records as necessary. It is also the responsibility of the parent/guardian to keep telephone and emergency information

updated on their child's emergency card and on account with the site director and the customer billing office.  (Initial)

**Medical and Emergency Incidents**

If a medical emergency arises, the Y staff will first attempt to contact the parent/guardian. If the parent/guardian cannot be reached, staff will try to contact emergency contacts until someone is reached. If the emergency is such that immediate hospital attention is necessary, the staff will

accompany the child to the hospital in an ambulance.  (Initial)

**Illnesses/Health Conditions**

Children may not attend the program if they have any illness or condition that compromises the health of other children or staff. Health Department regulations regarding periods of infection will be enforced. Children must be symptom-free (vomiting, fever, and diarrhea) for at least 24 hours before returning to the program. Additionally, a doctor's release will be required in order for any child to return to the center after a communicable illness.

(Initial)

**Damaged Property**

If a child accidentally or deliberately breaks or damages Y of Central Maryland property or the property at the site location, the parent/guardian will be

held responsible for the replacement cost of the equipment.  (Initial)

**Behavioral Issues and Suspension**

If a child is having problems adjusting to the program, a conference will be arranged between staff and parent/guardian. Serious behavioral problems may result in a suspension period with no reduction in tuition. A child may be dismissed from the program without notice if his/her behavior is consistently disruptive or if his/her behavior threatens the health and safety of himself or the safety of other children or staff. Additionally, if a

parent/guardian displays such behavior or acts within a manner that is inappropriate, his/her child may be dismissed from the program.  (Initial)

**Permissions/Other**

- I give my permission for my child to participate in walks and other activities within the grounds of the site.  (initial)
- I give the Y of Central Maryland permission to request a copy of my child's IEP enrollment/intake documentation and, if applicable, schedule of special education services (if applicable)  (initial)

**Special Considerations:** Please check off any of the following that you as a parent feel our Y staff should take into consideration in order to provide the

best experience for your child: ☐ Special nutritional or dietary needs ☐ Lower staff to student ratio (current ratio 1:15)

- Other considerations or comments:

**My signature indicates I have read and understand the Before and After School Enrichment Program Agreement. I agree to read the Parent Handbook in its entirety and to comply with all policies and procedures stated within. I understand failure to adhere to these policies may result in termination from the program. I certify that my child is fully able to participate in this program. In case of voluntary withdrawal, or if my child is removed from care, I understand there will be no refund of tuition fees for the period covered.**

Child's name:

Parent's name:

Date:



**Y of Central Maryland**  
**EFT Activity Authorization Form**  
**School Year 2015-2016**

Member #:

(Office Use Only)

Service Location

☐ **Before & After School Enrichment/ (Monthly, 1<sup>st</sup> day of month from Begin Date to 5/1/16)**

**Account information:**

Child's Name:

Phone (Cell):

Cardholder's Name:

Phone (Work):

Street Address:

City

State

Zip

Email Receipts to:

**Payment Information:**

Billing Method (Circle One): VISA MASTERCARD AMEX DISCOVER

Account Number:

Expiration (Month/Year):

Security Code (back of card):

**Preschool – 1st Date to run card:** [Click here to enter a date.](#)

Weekly Amount: \$

**Before & After School/Chips – 1st Date to run card:** [Click here to enter a date.](#)

Monthly Amount: \$

**Credit Card Electronic Fund Transfer Authorization and Agreement**

To THE Y OF CENTRAL MARYLAND (herein referred to as the Y): I have given my authority to charge the above named credit/debit card for the activity payments indicated above. It is understood that the Y's transmission of the EFT to the card issuer as payment becomes due and shall constitute valid notice of such payment due on the above named activity. When the above named EFT is processed, such charge shall constitute my receipt for the payment. Should any EFT not be honored by the card issuer, it is understood that payment is to be made by me within three (3) days for the amount of said payment, plus a service fee of \$25. I understand that this authorization will remain in effect only until the dates noted above. If I choose to terminate the EFT authorization prior to paying my tuition in full, I understand I must initiate its termination by giving the Y 30 days written notice in advance of the date I wish the EFT to stop. Failure to give 30 days written termination notice will result in that month's charge being non-refundable even in the event I am withdrawing my child from the Preschool/Before and After School Enrichment program. I further understand that all credit/debit card information changes must be given to the Y with 30 days written notice in advance of the date I want the change to occur.

I understand that after two unpaid charges, the Y may immediately terminate this agreement and Program enrollment until I have brought all payments up to date.

**I acknowledge the terms of the transfer authorization and agreement as stated above:**

Customer Name:

Customer Signature:

Date:

### **Registration Payment Instructions:**

- At time of registration parents will need to pay the full registration fee to secure a spot. The \$60 registration fee is non-refundable and non-transferrable.
- We request that registration fees be made either over the phone with our Customer Billing Department or with an Electron Funds Transfer (EFT) on file for initial registration.
- Families with current outstanding balances will not be able to register until their outstanding balance is paid.
- First payment for the first four weeks of enrichment programming is due on Aug 1<sup>st</sup>. Students who enrolled in the program after the official start date of the program will be prorated to reflect their start date.
- An additional prorated tuition payment may also be due depending on your start date; please contact Customer Billing with questions.
- Once payment is received Customer Billing will send a confirmation email confirming your completed registration, child's name, start date, and program type.

### **Monthly Online Payment Instructions:**

1. Go to the following link: <http://ymaryland.org/billinginquiries>. Select 'make payment'. Select 'program type' in the drop down box; type in child's first and last name; and type in child's program location. Then, select the 'Pay Now' button.
  - Type in the amount in the order summary and click "Update".
  - If you have a Paypal account, enter your Paypal login information and click "Pay Now to complete transaction using your debit, credit card, or checking account.
  - If you do not have a Paypal account, click "Don't have a Paypal account" and complete the required fields, including email address, phone number, and debit/credit card.

Please note: You do **NOT** have to have a PayPal account to make a payment online. There are 3 ways to pay:

2. From a computer, use your existing Paypal account:

- Click "Send Money"
- Type in the "To" field: [billing@ymaryland.org](mailto:billing@ymaryland.org)
- Type in the amount and select "I'm paying for goods and services"
- Select "no shipping required"
- In the "Message (optional)" box, **enter the child(ren)'s name and program location to ensure your account is credited correctly and timely.**

3. From a mobile device, use your existing Paypal account:

- Click "Send"
- Type in the "To" field: [billing@ymaryland.org](mailto:billing@ymaryland.org)
- Type in the amount
- In the Message box, **enter the child(ren)'s name and program location to ensure your account is credited correctly and timely**
- Under "What's this payment for?", select the button for goods or services
- Click "Review", then "Send"

Important note! Payments will be credited to your account the same day, but will not be reflected in our system until the following business day. A receipt will be sent to the primary email address on file; **please make sure this is current.** Also please note, **the online payment system cannot be used to secure your space in a Y program, only to pay an existing balance due.**

We encourage you to take advantage of the online payment option. However, should you need to speak with anyone from the Customer Billing department, please do not hesitate to call us at 443-322-8000. As always, billing questions, forms, and scanned documents can all be directed to our team by emailing [billing@ymaryland.org](mailto:billing@ymaryland.org).





Y of Central Maryland  
It's deeper here.®

## Before & After School Enrichment Payment Due Dates

### 2015-2016 School Year

If child starts during School Week beginning:	And ending:	Billing Start Date:	Number of Installments/ EFT:
Start of School Year	August 28, 2015	August 1, 2015	10
August 31, 2015	September 4, 2015		
September 7, 2015	September 11, 2015		
September 14, 2015	September 18, 2015		
September 21, 2015	September 25, 2015		
September 28, 2015	October 2, 2015	September 1, 2015	9
October 5, 2015	October 9, 2015		
October 12, 2015	October 16, 2015		
October 19, 2015	October 23, 2015		
October 26, 2015	October 30, 2015	October 1, 2015	8
November 2, 2015	November 6, 2015		
November 9, 2015	November 13, 2015		
November 16, 2015	November 20, 2015		
November 23, 2015	November 27, 2015	November 1, 2015	7
November 30, 2015	December 4, 2015		
December 7, 2015	December 11, 2015		
December 14, 2015	December 18, 2015		
December 21, 2015	December 25, 2015	December 1, 2015	6
December 28, 2015	January 1, 2016		
January 4, 2016	January 8, 2016		
January 11, 2016	January 15, 2016		
January 18, 2016	January 22, 2016		
January 25, 2016	January 29, 2016	January 1, 2016	5
February 1, 2016	February 5, 2016		
February 8, 2016	February 12, 2016		
February 15, 2016	February 19, 2016		
February 22, 2016	February 26, 2016	February 1, 2016	4
February 29, 2016	March 4, 2016		
March 7, 2016	March 11, 2016		
March 14, 2016	March 18, 2016		
March 21, 2016	March 25, 2016	March 1, 2016	3
March 28, 2016	April 1, 2016		
April 4, 2016	April 8, 2016		
April 11, 2016	April 15, 2016		
April 18, 2016	April 22, 2016		
April 25, 2016	April 29, 2016	April 1, 2016	2
May 2, 2016	May 6, 2016		
May 9, 2016	May 13, 2016		
May 16, 2016	May 20, 2016		
May 23, 2016	May 27, 2016	May 1, 2016	1
May 30, 2016	June 3, 2016		
June 6, 2016	June 10, 2016		
June 13, 2016	End of school year		



**Before & After School Enrichment      School Year 2015-2016**  
**ENROLLMENT & LIABILITY RELEASE/MEDICAL INFORMATION**

***Required for child to participate in program***

I am a legally competent adult who is parent or guardian of the named participant. I would like my child to participate in Y of Central Maryland programming and expressly give my permission. I understand that even when every reasonable precaution is taken, incidents and accidents may occur. Therefore, in exchange for the Y of Central Maryland allowing my child to participate, I voluntarily and intentionally hold harmless and release the Y, its directors, officers, employees and agents from all liability for loss, damage, injury, or death, including any claims based on ordinary negligence, action, or inaction connected in any way with such participation, except for any loss, liability, damage or cost that is caused solely by the Y's gross negligence. I also agree to indemnify the Y of Central Maryland for claims made by or for the participant or claims arising from any relationship with the participant or the participant's estate.

I have read this form and grant permission for my child, ,  
to participate in all activities provided by the Y of Central Maryland.

**Parent's signature**  **Date**

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

If my child, , should become ill or injured during Y activities, I understand that the Y will: 1) contact me immediately; 2) contact the person(s) I have designated in case I cannot be reached.

Should the Y be unable to reach me or the person(s) designated, the Y is authorized to contact my physician or arrange for immediate medical treatment to ensure the health and safety of my child, including the administration of medications or injections provided by me for such purpose.

I accept responsibility for payment of medical services rendered.

**Parent's signature**  **Date**

**MEDICAL ALERT INFORMATION** (list any allergies, medical and/or handicapping conditions)

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Physician name  Telephone

Physician address

Emergency Contact  Telephone

Emergency Contact  Telephone



**Before & After School Enrichment      School Year 2015-2016**

**EMERGENCY CARE PLAN**

**My child**  please check one: ☐ **does** / ☐ **does not** have an allergy.  
Child's name

*Sign form at bottom either way. Complete all information for allergies even if medication is not necessary.*

Grade:  Age:  Date of Birth:  Site:

Parent/Guardian Name:  Cell phone:

Work  phone:  Home phone:

Address:

**To provide assistance to this student experiencing an allergic reaction:**

**ACTIONS TO TAKE (Do This)**

**Stay calm.**  
**Stay with the child.**  
**Ask someone to contact 911 and/or parent**  
**Are medications at the Y program? Yes/No**  
**Medications on file to treat child:**

*In order for the Y to administer medication, a  
completed Medication Administration  
Authorization Form must be on file.*

Other care options:

Type of allergy:

Identify triggers which start an allergic  
reaction:

Possible allergic signs:

OTHER CONSIDERATIONS:

**CALL 911 if student has:**

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice

- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Becomes pale and floppy

**Administer CPR if breathing stops! Continue until paramedics arrive!**

I give consent for the Y of Central Maryland authorities to take appropriate action for the safety and welfare of my child. I give my consent for the Y of Central Maryland authorities to communicate with the authorized health care provider when necessary.

Parent Signature:

Date:

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

# HEALTH INVENTORY

## Information and Instructions for Parents/Guardians

### REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (*See* COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 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:  
[http://www.marylandpublicschools.org/MSDE/divisions/child\\_care/licensing\\_branch/forms.html](http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html) Select DHMH 896.
- **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:  
<http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf>

### EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their 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 provider or child care personnel who have a legitimate care responsibility for your child.

### INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

[http://www.marylandpublicschools.org/MSDE/divisions/child\\_care/licensing\\_branch/forms.html](http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html) Select OCC 1216.

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

**PART I - HEALTH ASSESSMENT****To be completed by parent or guardian**

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
Last                      First                      Middle			Mo / Day / Yr		
<b>Address:</b> _____					
Number      Street		Apt#	City	State	Zip
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>	<b>Phone Number(s)</b>		
		W: _____	C: _____	H: _____	
		W: _____	C: _____	H: _____	
<b>Where do you usually take your child for routine medical care? Name:</b> _____					
<b>Address:</b> _____			<b>Phone Number:</b> _____		
<b>When was the last time your child had a physical exam? Month:</b> _____ <b>Year:</b> _____					
<b>Where do you usually take your child for dental care? Name:</b> _____					
<b>Address:</b> _____			<b>Phone Number:</b> _____		
<b>ASSESSMENT OF CHILD'S HEALTH</b> - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>		
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time?</b>					
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____					
<b>Does your child receive any special treatments?</b> (nebulizer, epi-pen, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____					
<b>Does your child require any special procedures?</b> (catheterization, G-Tube, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____					
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
Signature of Parent/Guardian _____					Date _____



**PART II - CHILD HEALTH ASSESSMENT**  
**To be completed ONLY by Physician/Nurse Practitioner**

<b>Child's Name:</b> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 30%;">Last</span> <span style="width: 30%;">First</span> <span style="width: 30%;">Middle</span> </div>	<b>Birth Date:</b> <div style="border-bottom: 1px solid black; display: flex; justify-content: space-between; margin-bottom: 5px;"> <span style="width: 30%;">Month / Day / Year</span> </div>	<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
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1. Does the child named above have a diagnosed medical condition?

☐ No    ☐ Yes, describe:

2. 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:

**3. PE Findings**

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**REMARKS:** (Please explain any abnormal findings.)

**4. RECORD OF IMMUNIZATIONS** – DHMH 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: [http://www.marylandpublicschools.org/MSDE/divisions/child\\_care/licensing\\_branch/forms.html](http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html) Select DHMH 896.

**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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature:      Date:

5. 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).**

6. Should there be any restriction of physical activity in child care?

☐ No    ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No		

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
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## CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.**

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

### AT RISK AREAS BY ZIP CODE

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

CHILD'S NAME

LAST

FIRST

MI

SEX: MALE ☐ FEMALE ☐

BIRTHDATE

/

/

COUNTY

SCHOOL

GRADE

PARENT NAME

PHONE NO.

OR

GUARDIAN ADDRESS

CITY

ZIP

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type													
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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
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 DHMH 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 DHMH COMAR 10.06.04.03 are available at [www.dhmh.maryland.gov](http://www.dhmh.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.dhmh.maryland.gov](http://www.dhmh.maryland.gov). (Choose Immunization in the A-Z Index)

**This Brochure Provides Information About:**

- The requirements that State-regulated family child care homes and child care centers must meet,
- Your rights and responsibilities as the parent of a child in regulated care, and
- How and where to file a complaint if you believe your child care provider has violated State child care licensing regulations.

**Who Regulates Child Care?**

All child care in Maryland is regulated by the Maryland State Department of Education (MSDE), Division of Early Childhood Development. Within the Division, child care licensing is the specific responsibility of the Office of Child Care (OCC), Licensing Branch.

All child care facilities must meet minimum health, safety, and program standards set by Maryland law. To remain licensed, facilities must maintain compliance with those standards. Every licensed facility is inspected by OCC at least once each year to evaluate the facility's compliance with child care regulations.

OCC's thirteen Regional Offices are responsible for licensing activities, including:

- Issuing child care licenses;
- Inspecting child care facilities;
- Investigating complaints against licensed child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary to achieve compliance with regulations.

**There are two types of regulated child care facilities: family child care homes and child care centers.**

**Family Child Care Homes and Child Care Centers Must Meet the Following Requirements:**

- Have the approval of OCC, the fire department and other local agencies, as required (i.e., zoning, health, and environment).
- Provide care only in the areas of the facility that have been approved for use.
- Have the license issued by OCC posted where it is easily and clearly visible to parents. The license shows:
  - the maximum number of children who may be present at the same time;
  - the age groups which may be served; and
  - the facility's approved hours of operation.
- At all times, each child must be supervised in a manner appropriate to the child's age, activities, and individual needs.
- All areas of the facility used for child care must be clean, well lit, and properly ventilated. Room temperatures should be comfortable.
- If food service is provided, food must be stored, prepared, and served in a safe, sanitary and healthful manner.
- The facility must offer a daily program of indoor and outdoor activities that are appropriate to the age, needs and capabilities of each child.
- An up-to-date emergency information card must be on file and maintained for each child.
- The facility must post an approved emergency evacuation plan and conduct evacuation drills at least monthly.
- Child discipline procedures must be appropriate to a child's age and maturity level and may not include the deliberate infliction of physical or emotional pain. **Corporal punishment of any kind is strictly prohibited.**

**ADDITIONAL INFORMATION**

**The Maryland Child Care Credential**

Maryland has a voluntary child care credentialing program that recognizes child care providers' education, experience and professional activities at six levels. Credentialed providers are authorized and encouraged to display the seal issued by the MSDE Office of Child Care.



**Program Accreditation**

Child care programs have the option of becoming state or nationally accredited. Accreditation means that the facility and staff have met program standards of quality.

**Child Care and the Americans with Disabilities Act**

The federal Americans with Disabilities Act (ADA) requires all child care programs to make reasonable efforts to accommodate children with disabilities. For more information about the ADA, please contact the OCC Regional Office in your area or one of the following organizations:

**LOCATE: Child Care**

Maryland Committee for Children, Inc.  
608 Water Street  
Baltimore, MD 21202  
Phone: (410) 752-7588  
[www.mdchildcare.org](http://www.mdchildcare.org)

**Maryland Developmental Disabilities Council**

217 East Redwood Street, Suite 1300  
Baltimore, MD 21202  
Phone: (410) 767-3670  
(800) 305-6441 (within Maryland)  
[www.md-council.org](http://www.md-council.org)



**State of Maryland**  
Martin O'Malley, Governor  
**Maryland State Department of Education**  
Nancy S. Grasmick  
State Superintendent of Schools

OCC 1524 (rev. 12/2007)

**A  
PARENT'S  
GUIDE**

**TO**



**REGULATED**

**CHILD CARE**

\* \* \*

*Important Information for  
Parents of Children in  
Child Care Facilities*

A publication of the  
Maryland State Department of Education  
Division of Early Childhood Development  
Office of Child Care

[www.marylandpublicschools.org/MSDE/divisions/child\\_care/child\\_care.htm](http://www.marylandpublicschools.org/MSDE/divisions/child_care/child_care.htm)



There are certain requirements that apply only to homes or centers.

Family Child Care Homes

- Up to 8 children may be in care at the same time if the home meets certain physical requirements. No more than 2 children under the age of two, including the caregiver's own, may be in care at the same time unless the home has been approved to serve additional children in this age group and an additional adult is present. Under no circumstance may care be provided at the same time to more than 4 children under the age of two.
- Each applicant for a family child care license must:
  - Have a criminal background check and child abuse/neglect clearance;
  - Submit a recent medical evaluation; and
  - Complete pre-service training requirements, including certification in first aid and CPR.
- Each adult resident of the home must also have a criminal background check and child abuse/neglect clearance.
- After becoming licensed, the caregiver must periodically complete additional training. Also, current certification in first aid and CPR must be maintained at all times.
- Each caregiver must have at least one substitute who is available to care for the children in the event of the caregiver's temporary absence from the home. Each substitute is subject to approval by OCC and must have a child abuse/neglect clearance. If paid by the caregiver, a substitute must also have a criminal background check. Before allowing a substitute to provide care, the caregiver must tell the substitute how to reach parents in the event of an emergency and familiarize the substitute with the home's child health and safety procedures.

Child Care Centers

The center director and staff members who have group supervision responsibilities must meet minimum education, experience, and training qualifications. They must also meet continued training requirements each year.

- The director and all paid center employees must complete a criminal background check and a child abuse/neglect clearance, and submit a medical evaluation.
- In each classroom, staff/child ratios and maximum group size requirements must be maintained at all times. The following table shows some basic age groupings and the applicable requirements:
- | Age Group        | Ratio | Maximum Size |
|------------------|-------|--------------|
| 0 –18 months     | 1:3   | 6            |
| 18 – 24 months   | 1:3   | 9            |
| 2 years          | 1:6   | 12           |
| 3 –4 years       | 1:10  | 20           |
| 5 years or older | 1:15  | 30           |
- For every 20 children present, there must be at least one staff member who is currently certified in first aid and CPR.

Your Rights and Responsibilities as a Child Care Consumer

- You have the right to:
- Expect that your child's care meets the standards set by Maryland's child care licensing regulations (NOTE: the regulations are available online at: [www.marylandpublicschools.org/MSDE/divisions/child\\_care/regulat](http://www.marylandpublicschools.org/MSDE/divisions/child_care/regulat));
  - Visit the facility without prior notification any time your child is there;
  - See the rooms and outside play area where care is provided during program hours;
  - Be notified if someone in the family child care home smokes. In child care centers, smoking is prohibited;
  - Receive advance notice when a substitute will be caring for your child in a family child care home for more than two hours at a time;
  - Give written permission before a caregiver may take your child swimming, wading, or on field trips;
  - Give written authorization before any medication may be administered to your child;
  - Be notified immediately of any serious injury or accident. If your child has a non-serious injury or accident, you must be notified on the same day;
  - File a complaint with OCC if you believe that the caregiver has violated child care regulations.

- Any complaint you make to OCC about the care your child is receiving will be promptly investigated by OCC;
- Review the public portion of the licensing file for the facility where your child is or has been enrolled, or where you are considering enrolling your child.

How Do I File a Complaint?

If you wish to file a complaint, contact the OCC Regional Office in the area where the child care facility is located. Complaints may be filed anonymously. Listed below are Regional Offices and their main telephone numbers:

Region	
1 – Anne Arundel County	410-514-7850
2 – Baltimore City	410-554-8300
3 – Baltimore County	410-583-6200
4 – Prince George’s County	301-333-6940
5 – Montgomery County	240-314-1400
6 – Howard County	410-750-8770
7 – Western Maryland	
Hagerstown – Main Office	301-791-4585
Allegany Co. Field Office	301-777-2385
Garrett Co. Field Office	301-334-3426
8 – Upper Shore	410-819-5801
Caroline, Dorchester, Kent, Queen Anne’s and Talbot Counties	
9 – Lower Shore	410-713-3430
Somerset, Wicomico, and Worcester Counties	
10 – Southern Maryland	301-475-3770
Calvert, Charles and St. Mary’s Counties	
11 – North Central	410-272-5358
Cecil and Harford Counties	
12 – Frederick County	301-696-9766
13 – Carroll County	410-751-5438

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated.

If you need additional help, you may contact the main office of the OCC Licensing Branch:

Program Manager, Licensing Branch  
MSDE Office of Child Care  
200 West Baltimore Street, 10th Floor  
Baltimore, MD 21201  
410-767-7805

Dear Parent/Guardian:

Maryland child care regulations require your child care provider to verify that you received a copy of “A Parent's Guide to Regulated Child Care.” On the lines below, please write the name of each child you have placed in the care of this provider. **Complete and sign the statement at the bottom, tear off and give this portion of the brochure to the child care provider for retention in the facility’s files.**

Child: \_\_\_\_\_

Child: \_\_\_\_\_

Child: \_\_\_\_\_

Child: \_\_\_\_\_

I, \_\_\_\_\_, have received a copy of the consumer education brochure entitled “Parent’s Guide to Regulated Child Care.”

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

# EMERGENCY FORM

## INSTRUCTIONS TO PARENTS:

- Complete all items on this side of the form. Sign and date where indicated.
- 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  Last  First  Birth Date

Enrollment Date  Hours & Days of Expected Attendance

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

Parent/Guardian Name(s)	Relationship	Place of Employment:	Phone Number(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	C: <input type="text"/> H: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	W: <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	C: <input type="text"/> H: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	W: <input type="text"/>	<input type="text"/>

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  Last  First  Telephone (H)  (W)

Address

Street/Apt.#  City  State  Zip Code

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

Address

Street/Apt.#  City  State  Zip Code

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

Address

Street/Apt.#  City  State  Zip Code

Child's Physician or Source of Health Care  Telephone

Address

Street/Apt.#  City  State  Zip Code

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

Signature of Parent/Guardian  Date

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name  : Date of Birth

Medical Condition(s):

Medications currently being taken by your child:

Date of your child's last tetanus shot:

Allergies/Reactions

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for:

(2) If  signs/symptoms  appear,  do  this:

(3) To prevent incidents:

-----  
OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

COMMENTS:

  
  
**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

Telephone Number

**MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM**

Child Care Program: \_\_\_\_\_

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the facility.

Child's Picture (Optional)

**PRESCRIBER'S AUTHORIZATION**

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

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_  
(PRN=as needed)

If PRN, for what symptoms: \_\_\_\_\_

Possible side effects - Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: \_\_\_\_\_  
(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

**PARENT/GUARDIAN AUTHORIZATION**

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.

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

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

**SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: \_\_\_\_\_  
Signature Date

Parental approval: \_\_\_\_\_  
Signature Date

**FACILITY RECEIPT AND REVIEW**

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received: ☐ YES ☐ NO

Medication was received by: \_\_\_\_\_  
Signature of Person Receiving Medication and Reviewing the Form Date

## MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

[illegible]



**Maryland State Child Care/Nursery School  
Asthma Medication Administration Authorization Form  
ASTHMA ACTION PLAN for     /     /     to     /     /     (not to exceed 12 months)**



Triggers (list)

Student's

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PEAK FLOW PERSONAL BEST: \_\_\_\_\_

ASTHMA SEVERITY:   ☐ Exercise Induced   ☐ Intermittent   ☐ Mild Persistent   ☐ Moderate Persistent   ☐ Severe Persistent

**GREEN ZONE: Long Term Control Medication — use daily at home unless otherwise indicated**

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: \_\_\_\_\_
- ☐ Peak flow greater than \_\_\_\_\_ (80% personal best)

Medication	Dose	Route	Frequency

- ☐ Prior to exercise/sports/ physical education

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

**YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms**

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: \_\_\_\_\_
- ☐ Peak flow between \_\_\_\_\_ and \_\_\_\_\_ (50% 70% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in \_\_\_\_\_ minutes, notify the health care provider and parent/guardian.

**RED ZONE: Emergency Medications — Take these medications and call 911**

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or skin retracts between ribs
- ☐ Lips or fingernails blue
- ☐ Trouble waking or talking
- ☐ Other: \_\_\_\_\_
- ☐ Peak flow less than \_\_\_\_\_ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

**Health Care Provider and Parent Authorization**

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children] ☐ Yes   ☐ No

Prescriber signature: \_\_\_\_\_ Date: \_\_\_\_\_     Parent / Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Child Care Provider: Name: \_\_\_\_\_

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

## Allergy Action Plan

Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

Place Child's  
Picture Here

### TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	Give this Medication	
	Epinephrine	Antihistamine
But is <b>not</b> exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

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

\*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication	Dose:
Epinephrine:	
Antihistamine:	
Other:	

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

### EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact(s)	Name/Relationship	Phone Number(s)	
		Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

**\*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.**

Health Care Provider and Parent Authorization for Self/Carry Self Administration

I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer (school-aged only) ☐ yes ☐ No

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

# Allergy Action Plan (Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's  
Picture Here

**CHILD'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_


Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

**The Child Care Facility will:**

- ☐ Reduce exposure to allergen(s) by: (no sharing food, \_\_\_\_\_)
- ☐ Ensure proper hand washing procedures are followed. \_\_\_\_\_
- ☐ Observe and monitor child for any signs of allergic reaction(s). \_\_\_\_\_
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) \_\_\_\_\_
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity. \_\_\_\_\_
- ☐ \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_


**EpiPen®**  
(Epinéphrine) Auto-Injectors 0.3/0.15mg

userguide



**1**

**Pull off the blue safety release cap.**



**2**

**Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.**

**Phosphenol:** As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine, which can treat life-threatening allergic reactions. DO NOT INJECT INTO ANY MOUTH, DO NOT INJECT INTO YOUR BUTTOCK as this may not be effective for a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.

Call 911

**3**

**Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.**

**To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit [epipen.com](http://epipen.com).**

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**The Parent/Guardian will:**

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐ \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_