



Y of Central Maryland  
It's deeper here.™

## 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 that parents feel are most important in BASE - lots of love, attention, fun, games, homework help, and engaging activities in clean, safe environments where kids can learn while they play, make new friends, and get the engagement they need to grow and thrive. As a values-based organization, the Y of Central Maryland emphasizes character development. Personal growth in mind, body and spirit is what we're all about, and all of our programs and activities are designed to help children grow along this path.

For initial registration, only the registration form (page 2) is required. All families must complete the rest of the packet and return it via fax or email no later than August 15, 2014 for a school year start. **Children's files must be complete for program admittance.**

**All parents should submit paperwork by FAX to 410-779-9427 or email to [BASE@ymaryland.org](mailto:BASE@ymaryland.org)**

- Before & After School Enrichment Agreement
- Enrollment and Liability Release
- Parent's Guide to Regulated Child Care (new families only, please sign receipt)
- Emergency Contact Form
- Office of Child Care Health Inventory Form
- Immunization Certificate
- Allergy Emergency Care Plan
- Medication Authorization Form
- EFT Form (must be renewed annually)

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.

To maintain communication quality, please be sure to provide a primary email and phone number. These contacts will be the main form of communication with billing and the Y child care staff.

Please look for additional information on School's Out Days, Y Clubs and 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).

\*\* Emergency contacts

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

Sincerely,

Y Before and After School Enrichment Team



**Before & After School Enrichment      School Year 2014-2015**  
**PROGRAM REGISTRATION FORM: Northern Baltimore County**

Child's Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade (entering Fall 2014) \_\_\_\_\_

Gender    Male \_\_\_\_\_ Female \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Cell Phone \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Cell Phone \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

**Primary email address:** \_\_\_\_\_ **Primary phone number:** \_\_\_\_\_

**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 \_\_\_\_\_

**Enrichment Selection: Full-Time** (4-5 days per week)

**Part Time** (1-3 days per week)

**Hours of Operation** (all sites): Before School Enrichment opens at 7:00 a.m.; After School Enrichment ends at 6:00 p.m.

**School Site:** St. Joseph's

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

**Enrichment needed (please circle):**

Before School Enrichment Only      After School Enrichment Only      Both (Before and After School Enrichment)

Full Time (4-5 days)      Part Time (1-3 days)(circle days needed)      Mon      Tues      Wed      Thurs      Fri

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

<b>Monthly Rates</b>	<b>Full Time</b>	<b>Full Time</b>	<b>Part Time</b>	<b>Part Time</b>
	<b>Member</b>	<b>Open &amp; Youth</b>	<b>Member</b>	<b>Open &amp; Youth</b>
<b>Before Care</b>	<b>\$174</b>	<b>\$196</b>	<b>\$151</b>	<b>\$169</b>
<b>After Care</b>	<b>\$238</b>	<b>\$261</b>	<b>\$189</b>	<b>\$207</b>
<b>Before and After</b>	<b>\$344</b>	<b>\$389</b>	<b>\$273</b>	<b>\$311</b>

Only those with an active full time family Y membership(s) are eligible for the Full Time Member Rate (complimentary memberships do not apply). Registered full time before and after care participants will receive a complimentary youth membership, during the school year, which gives access to all Y of Central Maryland Family Center's facilities and discounts on select programming. A 10% sibling discount is also available, subject to restrictions. Payments are sent directly to the Customer Billing Office on a monthly basis for up to 10 months, depending on your child's start date. **First payment is due August 1 and last payment is due by May 1.** An additional pro-rated tuition payment may also be due depending on your start date; please contact Customer Billing for questions. A \$25.00 late fee is assessed after the 5<sup>th</sup> of each month. All cancellations and changes to care 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. Please see full credit/refund policy in Parent Handbook.

**School's 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. Full Time Before and After School participants will receive professional in-service days free.

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

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

**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.

Parent/Guardian signature \_\_\_\_\_

Date \_\_\_\_\_



## Before & After School Enrichment      School Year 2014-2015

### 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. Only those with an active full family Y membership are eligible for the Full Time Member Rate (complimentary memberships do not apply). \_\_\_\_\_(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, TCA, 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 Camp and clubs 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 clubs, 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 Camp**

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.\_\_\_\_(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 5 days 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 BASE 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)

**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: \_\_\_\_\_ Site: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's name: \_\_\_\_\_ Site: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I also give permission to the Y of Central Maryland to use without limitation of obligation, photographs, film footage, or tape recordings, which may include my child's image and/or voice for purposes of promoting and/or interpreting Y programs.*

Parent/Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

# EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____	C:	H:
		Place of Employment: _____	C:	H:

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  
**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://ideha.dhmh.maryland.gov/IMMUN/pdf/896\\_form.pdf](http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)
- **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/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216\\_MedAuth\\_r120511.pdf](http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf)

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

Child's Name:	Last	First	Middle	Birth date:	Mo / Day / Yr	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address:						
Number	Street	Apt#	City	State		Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)			
			W: <input type="text"/>	C: <input type="text"/>	H: <input type="text"/>	
			W: <input type="text"/>	C: <input type="text"/>	H: <input type="text"/>	
Where do you usually take your child for routine medical care? Name: <input type="text"/>						
Address:	Phone Number: <input type="text"/>					
When was the last time your child had a physical exam? Month: <input type="text"/> Year: <input type="text"/>						
Where do you usually take your child for dental care? Name: <input type="text"/>						
Address:	Phone Number: <input type="text"/>					
<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.						
	Yes	No	Comments (required for any Yes answer)			
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Does your child take medication (prescription or non-prescription) at any time?						
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): <input type="text"/>						
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: <input type="text"/>						
Does your child require any special procedures? (catheterization, G-Tube, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): <input type="text"/>						
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.						
Signature of Parent/Guardian				Date		

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

Child's Name: [REDACTED]			Birth Date: [REDACTED]		Sex																																																																																																								
Last	First	Middle	Month / Day / Year		M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																																																																								
<p>1. Does the child named above have a diagnosed medical condition?</p> <p><input type="checkbox"/> No    <input checked="" type="checkbox"/> Yes, describe: [REDACTED]</p> <p>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.</p> <p><input type="checkbox"/> No    <input checked="" type="checkbox"/> Yes, describe: [REDACTED]</p>																																																																																																													
<p>3. PE Findings</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Health Area</th> <th>WNL</th> <th>ABNL</th> <th>Not Evaluated</th> <th>Health Area</th> <th>WNL</th> <th>ABNL</th> <th>Not Evaluated</th> </tr> </thead> <tbody> <tr><td>Attention Deficit/Hyperactivity</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lead Exposure/Elevated Lead</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Behavior/Adjustment</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mobility</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Bowel/Bladder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Musculoskeletal/orthopedic</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cardiac/murmur</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neurological</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dental</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nutrition</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Development</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Physical Illness/Impairment</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Endocrine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Psychosocial</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ENT</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Respiratory</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>GI</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>GU</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Speech/Language</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hearing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Vision</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Immunodeficiency</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other: [REDACTED]</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>						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: [REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: [REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																						
<p>REMARKS: (Please explain any abnormal findings.)  [REDACTED]</p>																																																																																																													
<p>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 <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="http://ideha.dhmv.maryland.gov/IMMUN/pdf/896_form.pdf">http://ideha.dhmv.maryland.gov/IMMUN/pdf/896_form.pdf</a>)</p>																																																																																																													
<p><b>RELIGIOUS OBJECTION:</b>  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.</p>																																																																																																													
<p>Parent/Guardian Signature: [REDACTED] Date: [REDACTED]</p>																																																																																																													
<p>5. Is the child on medication?</p> <p><input type="checkbox"/> No    <input checked="" type="checkbox"/> Yes, indicate medication and diagnosis: [REDACTED]  <b>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).</b></p>																																																																																																													
<p>6. Should there be any restriction of physical activity in child care?</p> <p><input type="checkbox"/> No    <input checked="" type="checkbox"/> Yes, specify nature and duration of restriction: [REDACTED]</p>																																																																																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>7. Test/Measurement</th> <th>Results</th> <th>Date Taken</th> </tr> </thead> <tbody> <tr><td>Tuberculin Test</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> <tr><td>Blood Pressure</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> <tr><td>Height</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> <tr><td>Weight</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> <tr><td>BMI %tile</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> <tr><td>Lead Test Indicated: <input type="checkbox"/> Yes    <input checked="" type="checkbox"/> No</td><td>[REDACTED]</td><td>[REDACTED]</td></tr> </tbody> </table>						7. Test/Measurement	Results	Date Taken	Tuberculin Test	[REDACTED]	[REDACTED]	Blood Pressure	[REDACTED]	[REDACTED]	Height	[REDACTED]	[REDACTED]	Weight	[REDACTED]	[REDACTED]	BMI %tile	[REDACTED]	[REDACTED]	Lead Test Indicated: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	[REDACTED]	[REDACTED]																																																																																			
7. Test/Measurement	Results	Date Taken																																																																																																											
Tuberculin Test	[REDACTED]	[REDACTED]																																																																																																											
Blood Pressure	[REDACTED]	[REDACTED]																																																																																																											
Height	[REDACTED]	[REDACTED]																																																																																																											
Weight	[REDACTED]	[REDACTED]																																																																																																											
BMI %tile	[REDACTED]	[REDACTED]																																																																																																											
Lead Test Indicated: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	[REDACTED]	[REDACTED]																																																																																																											
<p>[REDACTED] (Child's Name) has had a complete physical examination and any concerns have been noted above.</p>																																																																																																													
<p>Additional Comments: [REDACTED]</p>																																																																																																													
Physician/Nurse Practitioner (Type or Print): [REDACTED]		Phone Number: [REDACTED]	Physician/Nurse Practitioner Signature: [REDACTED]		Date: [REDACTED]																																																																																																								

## **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 ALL</b>	<b>Baltimore (cont)</b>	<b>Cecil</b>	<b>Garrett</b>	<b>Montgomery</b>	<b>Prince George's (cont)</b>	<b>St. Mary's</b>
	21220	21913	ALL	20783	20782	20606
	21221			20787	20783	20626
<b>Anne Arundel</b>	<b>21222</b>	<b>Charles</b>	<b>Harford</b>	<b>20812</b>	<b>20784</b>	<b>20628</b>
20711	21224	20640	21001	20815	20785	20674
20714	21227	20658	21010	20816	20787	20687
20764	21228	20662	21034	20818		
20779	21229		21040	20838	20788	
21060	21234	<b>Dorchester</b>	21078	20842	20790	<b>Talbot</b> 21612
21061	21236	ALL	21082	20868	20791	21654
21225	21237		21085	20877	20792	21657
21226	21239	<b>Frederick</b>	21130	20901	20799	21665
21402	21244	20842	21111	20910	20912	21671
	21250		21160	20912	20913	21673
<b>Baltimore</b>	<b>21251</b>	<b>21703</b>	<b>21161</b>	<b>20913</b>		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					

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

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
1									1				Mo/Yr
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.

Clinic / Office Name

Office Address/ Phone Number

1. \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Medical provider, local health department official, school official, or child care provider only)
2. \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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

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

**MEDICAL CONTRAINDICATION:**

Please check the appropriate box to describe the medical contraindication.

This is a:  Permanent condition    OR     Temporary condition until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date \_\_\_\_\_

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **How To Use This Form**

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

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

### **Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## **Immunization Requirements**

The following excerpt from the 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)

# 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)

## 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)

**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 Allegany Co. Field Office Garrett Co. Field Office	301-791-4585 301-777-2385 301-334-3426
8 – Upper Shore Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties	410-819-5801
9 – Lower Shore Somerset, Wicomico, and Worcester Counties	410-713-3430
10 – Southern Maryland Calvert, Charles and St. Mary's Counties	301-475-3770
11 – North Central Cecil and Harford Counties	410-272-5358
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 \_\_\_\_\_



## Before & After School Enrichment

School Year 2014-2015

### ALLERGY EMERGENCY CARE PLAN

My child \_\_\_\_\_ does/does not have an allergy.

Child's name

(circle one)

*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:

Type of allergy: \_\_\_\_\_  
\_\_\_\_\_

Identify triggers which start an allergic reaction: \_\_\_\_\_  
\_\_\_\_\_

Possible allergic signs: \_\_\_\_\_  
\_\_\_\_\_

OTHER CONSIDERATIONS:  
\_\_\_\_\_  
\_\_\_\_\_

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

#### 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/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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.



**Before & After School Enrichment      School Year 2014-2015**  
**ENROLLMENT & LIABILITY RELEASE/MEDICAL INFORMATION**

Y of Central Maryland  
It's deeper here.®

***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)

\_\_\_\_\_

\_\_\_\_\_

Physician name \_\_\_\_\_ telephone \_\_\_\_\_

Physician address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ telephone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ telephone \_\_\_\_\_



Y of Central Maryland  
It's deeper here.®

[www.ymaryland.org](http://www.ymaryland.org)



**Before & After School Enrichment      School Year 2014-2015**

**INCLEMENT WEATHER POLICY- Baltimore County**

**Inclement Weather & Emergency Closing Policy  
2014-2015**

**Emergency School Closing**

If Baltimore County Public Schools close early due to an emergency, **the Y's Before and After School Enrichment program will NOT be able to provide care**. Site Directors and staff will alert families of the closing by calling the number listed under primary contact on the child's emergency contact form.

**After School Activities Cancellation** - The Y's BASE program operates separately from school-sponsored after school activities. We will strive to stay open until the scheduled closing time; however parents are encouraged to pick up their children as soon as possible.

**Late School Opening**

**One (1) Hour Delay** – The Y's Before and After School Enrichment program will be canceled. **No care will be provided.**

**Two (2) Hours Delay** – The Y's Before and After School Enrichment program will be canceled. **No care will be provided.**

**Full-Day School Closing**

Please watch local weather stations and news broadcasts about school closings. **If the schools are closed; the Y's Before and After School Enrichment programs will NOT provide care.**

**"Code Blue" School-closed Day** – The Y's BASE Programs will NOT be open.

**"Code Red" or "Code Green" School-closed Day** – The Y's Before and After School Enrichment programs will NOT be open.

**Y of Central Maryland Facilities Closing**

Y closing announcements will be made on TV stations 2, 11 and 13; and on radio stations WBAL 1090 AM and WMIX 106.5 FM. The Y of Central Maryland website will be updated during inclement weather events.

**Alternate Plan & Emergency Cards**

Each emergency/inclement weather event presents unique barriers that may prevent the Y from providing care therefore parents are encouraged to have an alternate plan for care locations and people to pick-up your child. Please make sure your child's emergency contacts cards are up-to-date, these cards will be used to contact parents during emergency closings.

These procedures have been established in conjunction with the Baltimore County Board of Education.



## Before & After School Enrichment

School Year 2014-2015

### PAYMENT INFORMATION PAGE

#### 4 Easy Ways to Make a Payment

1. Online payment options are available via our website at [www.ymaryland.org](http://www.ymaryland.org). See our Online Payment Instructions Page in this packet for more details.
2. For automatic billing, complete an EFT form (enclosed) and return it to the Billing Office.
3. Mail checks to the Customer Billing Office. See below for mailing address.
4. Call-in to the Customer Billing Office for over-the-phone credit card payments. See below for telephone number.

If full payment is not received by the 5<sup>th</sup> of the month, a late fee of \$25 will be assessed to your account. If payment is still outstanding on the 8<sup>th</sup> of the month, your care will be suspended until the full monthly tuition plus late fee is received. Contact the customer billing office immediately about special billing arrangements.

Payments cannot be given to staff.

We accept payments via money orders, American Express, Discover, MasterCard, and VISA. The Y will gladly accept your personal check, however, there will be a \$25 charge for any check returned to the Y unpaid by your bank.

#### Customer Billing Office/Contact Information

303 West Chesapeake Avenue  
Baltimore, MD 21204

Hours: 8:00 am – 5:30 pm

(p) 443-322-8000 option #1

(f) 410-779-9426

Email: [billing@ymaryland.org](mailto:billing@ymaryland.org)

\* Winter Break and Spring Break

#### 2014-2015 Payment Schedule

If Child Starts During Week of:	Billing Start Date:	Number of Installments/ EFT:
August 25, 2014- August 29, 2014	August 1, 2014	10
September 1, 2014-September 5, 2014		
September 8, 2014- September 12, 2014		
September 15, 2014- September 19, 2014		
September 22, 2014- September 26, 2014	September 1, 2014	9
September 29, 2014- October 3, 2014		
October 6, 2014- October 10, 2014		
October 13, 2014- October 17, 2014		
October 20, 2014- October 24, 2014	October 1, 2014	8
October 27, 2014- October 31, 2014		
November 3, 2014- November 7, 2014		
November 10, 2014- November 14, 2014		
November 17, 2014- November 21, 2014	November 1, 2014	7
November 24, 2014- November 28, 2014		
December 1, 2014- December 5, 2014		
December 8, 2014- December 12, 2014		
December 15, 2014- December 19, 2014	December 1, 2014	6
December 22, 2014- December 26, 2014*		
December 29, 2014- January 02, 2015*		
January 5, 2015- January 9, 2015		
January 12, 2015- January 16, 2015		
January 19, 2015- January 23, 2015	January 1, 2015	5
January 26, 2015- January 30, 2015		
February 2, 2015- February 6, 2015		
February 9, 2015- February 13, 2015		
February 16, 2015- February 20, 2015	February 1, 2015	4
February 23, 2015- February 27, 2015		
March 2, 2015- March 6, 2015		
March 9, 2015- March 13, 2015		
March 16, 2015- March 20, 2015	March 1, 2015	3
March 23, 2015- March 27, 2015		
March 30, 2015- April 3, 2015*		
April 6, 2015- April 10, 2015*		
April 13, 2015- April 17, 2015		
April 20, 2015- April 24, 2015	April 1, 2015	2
April 27, 2015- May 1, 2015		
May 4, 2015- May 8, 2015		
May 11, 2015- May 15, 2015		
May 18, 2015- May 22, 2015	May 1, 2015	1
May 25, 2015- May 29, 2015		
June 1, 2015- June 5, 2015		
June 8, 2015 - end of school year		



# Y of Central Maryland EFT Activity Authorization Form School Year 2014-2015

PRESCHOOL (Weekly, Fridays from Begin Date to 8/7/2015)

Service Location: \_\_\_\_\_

BASE (Monthly, 1st day of month from Begin Date to 5/1/2015)

## Account information, please print:

Child's Name \_\_\_\_\_

Phone (Home) \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Phone (Work) \_\_\_\_\_

Member # \_\_\_\_\_

Phone (Cell) \_\_\_\_\_

Street Address \_\_\_\_\_

Email receipts to: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

## Payment information:

Billing Method (Circle one): VISA MASTERCARD AMEX DISCOVER

Preschool - Begin Date: \_\_\_\_\_

Account Number: \_\_\_\_\_

Weekly Amount: \$ \_\_\_\_\_

Expiration (Month/Year) \_\_\_\_\_

BASE - Begin Date: \_\_\_\_\_

Security code (back of card) \_\_\_\_\_

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/BASE 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 (print): \_\_\_\_\_

Customer Signature: \_\_\_\_\_

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



Before & After School Enrichment      School Year 2014-2015

## ONLINE PAYMENT INSTRUCTIONS PAGE

### Online Payment Instructions

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

1. Go to the following link: <http://ymaryland.org/enrichment-before-after-school>. 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.
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 Youth Enrichment 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).