Preschool Welcome Letter

2014-2015 School Year

Welcome to the Y of Central Maryland. We are delighted that you have chosen to enroll your child in our program. **Our curriculum-based program is rated parent's number one choice in preschool programs.** Here are some helpful hints that should get your child off to a great start:

1. The following information must be completed and returned to Cheryl Rosendahl **prior** to your child's first day. The packet can be mailed to: Hill Family Y Center, 1719 Sykesville Rd, Westminster MD 21157 attn: Cheryl Rosendahl.

   - Registration Form w/Registration Fee
   - Emergency Card
   - Enrollment/Liability Release
   - Allergy Emergency Care Plan
   - Swim Permission Slip *(if applicable)*
   - Payment for One Month's of Care
   - Registration Agreement
   - Financial Issues Statement
   - Immunization Record
   - New Health Inventory Form w/Lead Addendum

2. Please contact the billing department at 443-322-8000 to ensure that you understand our tuition requirements and other financial issues **prior** to your child's first day.

3. On your child's first day, please bring the following items labeled with your child's name:

   - Diapers and wipes *(if child is not yet potty trained)*
   - Gallon Ziploc bag with a complete change of clothing inside
   - A nutritious packed snack *(with nothing to heat up please)*
   - MWF 4's should bring a nutritious packed lunch which doesn't need to be heated
   - A Family picture

4. Tuition Payments are due the first of every month. Payments can be made online, over the phone, via EFT (electronic funds transfer), check, or money order and should be made out to the Y. **A late charge of $25 will be applied to any account not paid in full by the due date.**

5. Your child will be assigned a cubby and a mailbox. When you drop off your child, please sign them in, put their belongings in their cubby, and escort them to their classroom. When you pick your child up, please sign them out, collect their items from their cubby, and check their mailbox for information/projects to be sent home.

6. In each classroom you will find a parent board with information on our curriculum, lesson plans, and daily routines.

7. Please do not bring toys from home into the center. We provide plenty of activities for your child to enjoy.

Thanks again for enrolling your child in our program. Please contact us if you have any questions or concerns.

the Y Preschool
Y of Central Maryland
It's deeper here.

Office Use Only:
Start Date: _____Class: _____
Amt Owed_____ Amt Paid_____
❑ Teacher Notified Initials_____

Y Chipmunks Preschool • 410-848-2772

2014-2015 Student Registration Form

Student's Name _____ Date of Birth _____ Gender _____

Parent/Guardian #1 _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Parent/Guardian #2 _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Allergies (Must complete Allergy Action Plan): _____

Does your child require any special accommodations or a lower child/staff ratio than what MSDE OCC mandates ? If yes, this office will contact you prior to enrollment. □ Yes □ No

Demographic Information (Optional)

Race	□ Black/ African American	□ Asian	□ Hispanic/ Latino	□ Native Hawaiian/ Other Pacific Islander	□ American Indian/ Native American	□ White/ Caucasian	□ Other: _____
Household Income	□ $0-$15,000	□ $15,001-$24,999	□ $25,000-$39,999	□ $40,000-$74,000	□ $74,001-$99,999	□ $100,000	

Enrollment Options
Please note that each enrollment option is subject to availability. Fees are monthly unless otherwise noted. Service begins September 2014. Tuition rates for those with Y Full Family Memberships are shown as "monthly member rate".

Registration Fee: *Non-Refundable* **$ 100.00** +

1 Month Advance Payment: **$** _____ =

Total Due: **$** _____

Enrollment Modifications:_____

Indicate Class Choice (1st and 2nd)	Class	Time	Monthly Member Rate*	Monthly Open Rate
	Twos – Mon/Wed	**9:15-11:45**	**$165**	**$175**
	Twos – Tues/Thur	**9:30-12:00**	**$165**	**$175**
	Twos – Fri	**9:15-11:45**	**$85**	**$90**
	Threes – Tues/Thur	**9:15-11:45**	**$160**	**$170**
	Threes – Mon/Wed/Fri	**9:30-12:00**	**$205**	**$215**
	Threes – Mon/Wed/Fri PM	**12:45-3:15**	**$185**	**$195**
	PreK Fours – Mon thru Fri	**9:15-11:45**	**$230**	**$240**
	PreK Fours – Mon/Wed/Fri	**9:30-2:30**	**$260**	**$270**

***Tuition discount only applies to those with a full family Y membership.**

Permissions: *(Please make a selection for each)*

I give Y Chipmunks permission to take photographs of my child. Please indicate whether you consent to internal sharing of the photographs, external (marketing) sharing of the photographs, both, or none.	**INTERNAL**	**EXTERNAL**	**BOTH**	**NONE**
I give Y Chipmunks permission to use diapers, wipes, rash ointments and other creams on my child, which I understand I am to provide labeled with my child's name.	**YES**	**NO**		
I give Y Chipmunks permission to transport my child for emergency purposes.	**YES**	**NO**		
I am aware that "The Parent's Guide to Regulated Child Care" is located on the Y Chipmunks Parent Information Table and that I may request a copy of it from my school director or I can find this document at *www.marylandpublicschools.org/MSDE?division?Child_care/Child_care.html* .	**YES**	**NO**		

I have read and understand all of the statements shown above.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Director/Admin. Signature **Date**

Chipmunks Preschool Registration Agreement

2014-2015 School Year

Child's Name_____ Date of Birth:_____

Parent/Guardian Name_____

Please review the following information to ensure that you understand your responsibilities in enrolling your child in the Y Preschool Program. This signed agreement will be placed in your child's file and a copy provided for your records upon request.

1. I agree to pay a non-refundable registration fee at the time of enrollment. I also agree to pay for the sum of one month's tuition in advance. I understand that in order to continue my child's enrollment, each year I must pay an annual non-refundable program and curriculum fee._____(initial)

2. I understand that tuition is due the first of every month. I understand that care may be terminated if my account is past due. A late charge of $25.00 will be applied to any account not paid in full by the due date. Tuition prices are subject to change. Only those with an active full family Y membership are eligible for the tuition member rates._____(initial)

3. I have received a copy of the Financial Issues Statement, which explains payment policies, registration fees, tuition fees, change in care, late fees, late pick-up fees, vacation credits, and financial assistance. I will receive a Holiday Schedule and understand that payment is due for Holiday closings, sick days, emergency closings, and other absences._____(initial)

4. I understand that all changes in scheduled care must be made in writing through the Center Office at least one month in advance. Verbal notifications of changes or withdrawals cannot be accepted. There is a $10 processing fee for refunds and changes in care._____(initial)

5. I understand that my child must be escorted by an adult (18 years or older) to a Y staff member in the center. The adult must also sign the in/out roster to ensure that this safety regulation is enforced._____(initial)

6. I understand that it is my responsibility to notify the center staff of any family/medical information pertinent to my child's health, safety and well-being; and to provide updated medical records as necessary. Additionally, I will keep work and emergency contact and phone numbers up-to-date._____(initial)

7. If there are any custody issues, I 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. I understand 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. I understand that I must communicate with the other parent in regards to information on the care and education of my child and refrain from placing Y staff in the middle of any custody issues. Failure to do so could result in termination of care._____(initial)

8. I understand that if my child is having problems adjusting to the program, a conference will be arranged between the staff and myself._____(initial)

9. I understand that I may be asked to withdraw my child from the program if their behavior threatens their own safety and/or health, or that of other children and staff in the Center. If possible, a two-week period will be allowed for parents to make alternative care arrangements. For more serious offenses, I understand that I may be called immediately to pick up my child and he/she may be suspended or expelled from care without prior warnings. Some examples of this include, but are not limited to: disrupting the classroom setting, hitting, punching, kicking, or biting another student or teacher. Credit is not issued for days of suspension._____(initial)

10. I understand that care may be terminated if my behavior does not fit within the core values of the Y; if I do not follow Y policies; or if I become aggressive toward any Y staff, parents, or children._____(initial)

11. If my child becomes ill or if a medical emergency arises, the staff will first attempt to contact me and I will be required to pick my child up within an hour of receiving the call. If I cannot be reached, emergency contacts and/or my child's doctor will be contacted._____(initial)

12. I understand that my child 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. I understand that my child must be symptom free (vomiting, fever, and diarrhea) for at least 24 hours before returning to the Center. Additionally, a doctor's release will be required in order for my child to return to the center after a contagious illness. I have reviewed the health policy as provided in the Y Parent Handbook, which explains the Maryland State Health Department's requirements on medication, periods of infection, attendance, and immunization._____(initial)

13. I understand that an alternate care plan must be made in advance for illness and emergency closings. I also understand that I am still required to pay should these situations arise._____(initial)

14. I give permission for my child to participate in walks within the grounds of the Center._____(initial)

15. I give permission for my child to participate in the Y instructional swim classes (if applicable)and water play days as part of the program._____(initial)

16. I give permission for my child to be transported by the use of Y buses (if applicable). I also understand that I will receive a permission slip to sign for any field trips off of the center grounds._____(initial)

17. If my child deliberately destroys Y (or school) property, I understand that I will be held responsible for the replacement cost of the property._____(initial)

18. I understand that my child may be exposed to classroom pets in the preschool center, including but not limited to fish, guinea pigs, hamsters, gerbils, rabbits, and other small animals._____(initial)

19. By signing this agreement, I acknowledge that I am the responsible party for payment of all fees and tuition._____(initial)

20. I understand that I must allow at least 5 business days for any paperwork requests._____(initial)

My signature indicates I have read and understand the Preschool Registration 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:_____ Date:_____

Parent's signature:_____ Date:_____

Preschool Financial Issues Statement

2014-2015 School Year

Child's Name_____ Date of Birth:_____

Parent/Guardian Name_____

The Y is a non-profit 501 (c)3 organization. Our rates are reflective of our actual costs in providing comprehensive, quality-based care. Please support our efforts to keep costs down by understanding our financial issues and adhering to the policies and procedures for these services.

Tuition Fees

Registration must be done each year and an annual registration fee must be paid. Payment for tuition is due the first of every month. Only those with an active full family Y membership are eligible for discounted preschool tuition rates. Membership discounted rates are not applicable for complimentary membership offers.

Payment Policies

Payment can be made by check, money order, or credit card. Please put your child's name on the check or money order. We offer the option of having your credit card number on file and automatically charging it for each tuition payment - EFT (Electronic Funds Transfer) payment method, or you may pay online. Make check or money order payable to the Y of Central Maryland. Mail your payment to the Billing Office, or make payment at the membership desk at your local Y Health and Wellness Center. A receipt will be provided only upon request.

Late Payment Policy

A late charge of $25 will be applied to any account not paid in full by the due date. If payment is late, then parents will receive either a note or a phone call concerning late payments and a date for termination of services if payment is not received. To avoid disruption of service, payment must be made in full by the final termination date; and you must provide receipt of payment to the center director or opening staff before your child will be admitted into care. Personal checks will not be accepted on delinquent accounts or if a personal check has been refused for payment (NSF-non sufficient funds) by our financial institution within the last 12 months.

Bad Checks

Checks that are returned for non-payment will not be re-deposited. An additional charge of $25.00 will be charged for any returned checks. We will notify you by phone or letter of a Non-Sufficient Funds occurrence. The $25.00 fee will be added to your next payment. Multiple returned checks may result in the Y not being able to accept personal checks for payments.

Change in Tuition

Tuition fees are subject to change. Written notice will be given in advance regarding such a change. If your child needs to have any changes in their enrollment, request must be made in writing at least one month in advance. Verbal changes cannot be accepted. There is a $10.00 processing fee for refund or change in care requests.

Credits

There is no reduction in fees if a child is absent from the program or if the site is forced to close due to circumstances beyond our control.

Late Pick-Up Charge

Late fees begin at the close of business and are assessed as follows: $5.00 for the first five minutes and $5.00 for each 5-minute period thereafter or fraction thereof. Parents who are late will be presented with a Late Charge Slip, and asked to sign/verify the late balance being assessed. Parents are responsible for paying the accrued late charges by the close of the next business day. (Regulations require that two staff members must stay at the center until every child is picked up. Staff who work overtime are required to be paid time and a half salary.) Please remember that late parents must call the center to inform the staff of the delay. Ten minutes after the close of business, emergency contacts will be notified to arrange pick-up of the child. If we can not reach either you or your emergency contacts to pick up your child, then we will contact Child Protective Services. Parents with excessive, unexcused, late pick-ups will be given notice to find alternate care.

Financial Assistance

Financial Assistance may be available to qualifying families. Verification of income is required and applications are renewed and reviewed on a quarterly basis. Applications are available from the business office.

I have read and understand the above.

Parent/Guardian's Signature: _____ Date: _____

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/CHIPMUNKS (Monthly,1st day of mo from Begin Date to 5/1/15) ☐

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

Account Number: _____

Expiration (Month/Year) _____

Security code (back of card) _____

Preschool - Begin Date: _____

Weekly Amount: $ _____

BASE/Chips-Begin 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/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: _____

Y of Central Maryland
It's deeper here.®

Preschool Online Payment Instruction Page

2014-2015 School Year

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/preschool-headstart/preschool. 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
   - 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
   - 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.

the Preschool
Y of Central Maryland
It's deeper here.

ALL ABOUT ME INFORMATION

My immediate family includes: (please include names)

_____

_____

_____

I live in a (circle what applies): neighborhood farm city

Pets (names and what kind?):_____

_____

What holidays do you celebrate as a family? _____

_____

Child's favorite food is_____

Child's favorite toy/game is_____

I don't like_____

What does Mommy do? _____

What does Daddy do? _____

Any special talents someone in the family could share with the class?

_____

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: _____ W:	C:	H:
		Place of Employment: _____ W:	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 _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

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

Address _____
Street/Apt.# City State Zip Code

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

Address _____
Street/Apt.# City State Zip Code

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

Address _____
Street/Apt.# City State Zip Code

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

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

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

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

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

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

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

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number

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*
- ***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-CC9405971A42/36556/1216_MedAuth_073013.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: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Where do you usually take your child for routine medical care? Name:

Address: **Phone Number:**

When was the last time your child had a physical exam? Month: Year:

Where do you usually take your child for dental care? Name:

Address: **Phone Number:**

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

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, etc.)

☐ No ☐ 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.

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: Last / First / Middle	**Birth Date:** Month / Day / Year	**Sex** M ☐ F ☐

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	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

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://marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/docs/DHMH_896_revFeb2011.pdf)

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

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: ☐Yes ☐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:

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219

Baltimore (cont)
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

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

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

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

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781

Prince George's (cont)
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

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. (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. (Choose Immunization in the A-Z Index)

Y of Central Maryland
It's deeper here.®

Preschool Allergy Emergency Care Plan

2014-2015 School Year

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.

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 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 Heath 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.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Preschool Enrollment and Liability Release/Medical Information

2014-2015 School Year

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_____

Chipmunks Inclement Weather Policy

2014-2015 School Year

The following procedures will be in effect in the event of inclement weather:

- If Carroll County schools are closed, then Chipmunks will be closed for the day.
- If Carroll County schools announce a delayed opening, then Chipmunks classes start at 10:00 am that day.

Parents should check for updates regarding weather-related closings on their email and on the home page of our website at www.ymaryland.org.