



"2024" I.M.P.R.O.V.E. Children Summer Program **CONTRACT**

Payments must be in the form of cash, money orders or cashier checks.

I, _____, agree that the I.M.P.R.O.V.E. Children Program (ICP) at Loch Raven United Methodist Church will provide childcare for my child/children _____,

June 24, 2024 – August 16, 2024. I understand that the program will close on Thursday & Friday July 4 & 5 in observance of the Fourth of July Holiday. We will close at 12:30 pm on Friday, August 16, 2024 (the last day of camp).

For this service I agree to pay ICP \$ _____ per week. Payments must be made 2 weeks in advance. Payments are due every other Monday. Scholarship out of pocket fees are due the first of every month. A \$30.00 per day late fee will be charged for late payments. If I exceed the designated time for picking up my child, I will be obligated to pay an extra \$30.00 for every 15 minutes per child for extended care. If my child arrives at the program before 7:30 am, I am responsible for paying an extra fee of \$15 per day, unless I sign up for before care which is an extra \$25 per week. I understand that refunds are not given (for any reason) if I decide not to send my child to the program on the days in which ICP is responsible for caring for my child/children.

The I.M.P.R.O.V.E. Children Program understands that this is peak vacation time for most families. Therefore, we will allow your child to be absent for one week, (Mon – Fri) in which you will only be responsible for ½ weeks payment. We must receive a letter at least 2 weeks prior to vacation time with the vacation dates written down. If the program is not notified at least two weeks before your child's vacation, you will be responsible for the full payment. **Vacation fees are only allowed for children who are enrolled in the 8 week session.**

A free nutritious breakfast, lunch and snack will be provided for 8 weeks. If you choose to send a lunch with your child, it must be a cold lunch, with an ice pack. We will not let children eat perishables that are not stored in their lunch boxes correctly. Also, we do not heat food.

During summer, masks will be optional. However, if we feel the need to reinstate the mask policy, all staff and children will be required to comply. If we believe your child is starting or getting over a contagious upper respiratory illness, we will give them a mask.

We respectfully ask all parents and adults who are designated to pick up and drop off children to not enter in the church building under the influence or smelling of drugs (marijuana) and alcohol. If this request is ignored by parents, or guardians who pick up children, your child's contract will be terminated by IMPROVE and Ms. Viola will meet with you, if needed. We understand that marijuana is sometimes used for medicinal purposes, however, please keep in consideration the side effects that the smell can have on the children, staff, and younger siblings of the families who may be present. If you have any questions about this policy, please contact Ms. Viola via her cellular phone: 410-215-4604.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____



IMPROVE CHILDREN PROGRAM

“ 202 ” REGISTRATION FORM

**Please circle one: Summer Camp or Virtual Learning Program Date:* _____

Name of Child: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of School: _____ Grade: _____

Parent's Name _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell # _____

Employer: _____ Occupation: _____

Wk. Address: _____ Wk#: _____

Other # _____ Parent's E – mail address: _____

Parent's Name _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell # _____

Employer: _____ Occupation: _____

Wk. Address: _____ Wk#: _____

Other # _____ Parent's E – mail address: _____

Emergency Contact Person (PLEASE USE BACK FOR ADDITIONAL EMERGENCY CONTACTS, IF NOT ENOUGH SPACE)

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Cell#: _____ Other#: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Cell#: _____ Other#: _____

What is your child's favorite activity and foods they like to eat?

Does your child play well with others?

Do you think your child will benefit from stress and time management class?

Does your child occupy his/her time in a positive way?

Does your child have any medical problems (asthma, allergies etc.)?

Please explain

Does your child take medication for any reason?

Please explain

Is your child allergic to any particular food?

Does your child have any special needs?

Does your child have an IFSP/IEP, if so would you like to provide all or part of the IFSP/IEP? _____

Is there any other important information we need to know about your child? _____

**IF YOUR CHILD HAS HAD ASTHMA IN THE PAST OR CURRENTLY HAVE ASTHMA, WE
MUST HAVE AN INHALER FOR THEM AT ALL TIMES !**

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes: No:

Meals your child will receive while in care:
 BK LN SU AM Snk PM Snk Evng Snk

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
 Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) _____
 Last First Relationship to Child

Address _____
 Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____ Date _____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

INSTRUCTIONS TO PARENT/GUARDIAN:

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

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

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

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

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

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- **A physical examination** by a health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

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

Child's Name: _____			Birth date: _____		Sex
_____ Last _____ First _____ Middle _____			_____ Mo / Day / Yr		M <input type="checkbox"/> F <input type="checkbox"/>
Address: _____					
_____ Number _____ Street _____		_____ Apt# _____ City _____		_____ State _____ Zip _____	
Parent/Guardian Name(s)		Relationship		Phone Number(s)	
_____		_____		W: _____ C: _____ H: _____	
_____		_____		W: _____ C: _____ H: _____	
Medical Care Provider		Health Care Specialist		Dental Care Provider	
Name: _____		Name: _____		Name: _____	
Address: _____		Address: _____		Address: _____	
Phone: _____		Phone: _____		Phone: _____	
				Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Child Care Scholarship <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Last Time Child Seen for Physical Exam: Dental Care: Specialist:	
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?					
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					Date _____

PART II - CHILD HEALTH ASSESSMENT
To be completed **ONLY** by Health Care Provider

Child's Name: _____			Birth Date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Last	First	Middle	Month / Day / Year				
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child receive care from a Health Care Specialist/Consultant? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card. <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
4. Health Assessment Findings							
Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:			
REMARKS: (Please explain any abnormal findings.)							
5. Measurements		Date		Results/Remarks			
Tuberculosis Screening/Test, if indicated							
Blood Pressure							
Height							
Weight							
BMI % tile							
Developmental Screening							
6. Is the child on medication? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis: (OCC 1216 Medication Authorization Form must be completed to administer medication in child care). https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms							
7. Should there be any restriction of physical activity in child care? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
8. Are there any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
9. RECORD OF IMMUNIZATIONS – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)							
10. RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620) Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.							

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

How To Use This Form

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

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

Notes:

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

Immunization Requirements

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

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

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

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

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

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

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

**Maryland State Department of Education
Office of Child Care
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's
Picture Here
(optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: ____/____/____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: ____/____/____ to ____/____/____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions: _____

Known Food or Drug Allergies: Yes No If yes, please explain: _____

For School Age children only: The child may self-carry this medication: Yes No

The child may self-administer this medication: Yes No

PRESCRIBER'S NAME/TITLE

Place Stamp Here (Optional)

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** Yes No

PARENT/GUARDIAN SIGNATURE

DATE (mm/dd/yyyy)

INDIVIDUALS AUTHORIZED TO PICK UP
MEDICATION

CELL PHONE #

HOME PHONE #

WORK PHONE #

CHILD CARE STAFF USE ONLY

- | | | |
|------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Child Care Responsibilities: | 1. Medication named above was received. Expiration date _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 2. Medication labeled as required by COMAR. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 3. OCC 1214 Emergency Form updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 4. OCC 1215 Health Inventory updated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | 6. Staff approved to administer medication is available onsite, field trips | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Reviewed by (printed name and signature): _____

DATE (mm/dd/yyyy)

Maryland State Department of Education

Office of Child Care

MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				Date of Birth:	
Medication Name:				Dosage:	
Route:				Time to Administer:	
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last) _____

2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____

3. Child's picture (optional)

4. ASTHMA SEVERITY: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise Induced Peak Flow Best ____ %
 5. ASTHMA TRIGGERS (check all that apply): Colds URI Seasonal Allergies Pollen Exercise Animals Dust Smoke Food Weather Other _____

Section I. ASTHMA ACTION PLAN

6. FOR ASTHMA MEDICATIONS ONLY - THIS FORM REPLACES OCC 1216. This authorization is NOT TO EXCEED 1 YEAR

6a. FROM ____/____/____

6b. TO ____/____/____

GREEN ZONE - DOING WELL: Long Term Control/Medication- Use Daily At Home unless otherwise indicated

OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has ALL of these

Medication Name

Dose

Route

Frequency

Special Instructions

- Breathing is good
 - No cough or wheeze
 - Can walk, exercise, & play
 - Can sleep all night
- If known, peak flow greater than _____
(80% personal best)

Exercise Zone

CALL 911

CALL PARENT

OTHER:

OK to Self-Carry Yes No OK to Self-Administer Yes No

- Prior to all exercise/sports
- When the child feels they need it

Rescue Medication

Dose

Route

Frequency

Special Instructions

YELLOW ZONE - GETTING WORSE

CALL 911

CALL PARENT

OTHER:

OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has ANY of these

- Some problems breathing
- Wheezing, noisy breathing
- Tight chest
- Cough or cold symptoms
- Shortness of breath
- Other: _____

If known, peak flow between _____ and _____ (50% to 79% personal best)

RED ZONE - MEDICAL ALERT/DANGER

CALL 911

CALL PARENT

OTHER:

OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has ANY of these

- Breathing hard and fast
- Lips or fingernails are blue
- Trouble walking or talking
- Medicine is not helping (15-20 mins?)
- Other: _____

If known, peak flow below _____
(0% to 49% personal best)

Medication Name

Dose

Route

Frequency

Special Instructions

ASTHMA ACTION PLAN AND MEDICATION AUTHORIZATION FORM

CHILD'S NAME (First Middle Last)

DATE OF BIRTH (mm/dd/yyyy) ____/____/____

Section II. PRESCRIBER'S AUTHORIZATION

Place Stamp Here

8. PRESCRIBER'S NAME/TITLE

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIP CODE

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
(original signature or signature stamp only)

9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the childcare program may revoke the child's authorization to self-carry/self-administer medication.
(School Age Children Only) OK to Self-Carry Yes No **OK to Self-Administer** Yes No

10a. PARENT/GUARDIAN SIGNATURE

10b. DATE (mm/dd/yyyy)

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. CELL PHONE #

10e. HOME PHONE #

10f. WORK PHONE #

Emergency Contact(s)

Name/Relationship

Phone Number to be used in case of Emergency

Parent/Guardian 1

Parent/Guardian 2

Emergency 1

Emergency 2

Section IV. CHILD CARE STAFF USE ONLY

- Child Care Responsibilities:
1. Medication named above was received Yes No
 2. Medication labeled as required by COMAR Yes No
 3. OCC 1214 Emergency Card updated Yes No
 4. OCC 1215 Health Inventory updated Yes No
 5. Modified Diet/Exercise Plan Yes No N/A
 6. Individualized Plan: IEP/IFSP Yes No N/A
 7. Medication Administration log attached to this form Yes No
 8. Staff approved to administer medication is available onsite, field trips Yes No

Reviewed by (printed name and signature):

DATE (mm/dd/yyyy)