TINY TOTS: RATES & ATTENDANCE

To enroll, initial preferred rate/attendance option below. Submit completed form to Shelly Regars. Upon approval, a signed copy of this form will be returned to you.

PART TIME	TIME	MONTHLY RATE	INITIAL
TUES, THURS	9:00AM - 12:00PM	$120	
	9:00AM - 1:30PM	$180	
	9:00AM-3:30PM	$260	
	6:30AM - 6:00PM	$390	

PART TIME	TIME	MONTHLY RATE	INITIAL
MON, WED, FRI	9:00AM - 12:00PM	$180	
	9:00AM - 1:30PM	$270	
	9:00AM - 3:30PM	$340	
	6:30AM - 6:00PM	$590	

FULL TIME	TIME	MONTHLY RATE	INITIAL
MON - FRI	9:00AM - 12:00PM	$260	
	9:00AM - 1:30PM	$390	
	9:00AM - 3:30PM	$550	
	6:30AM - 6:00PM	$790	

DROP-IN::
Depending on staffing availability, we may be able to accommodate "drop-in" attendance for enrolled students on days/times that they would normally not attend. All requests must be pre-approved.
$35.00 HALF DAY (6:30am-12:00pm OR 12:00pm-6:00pm) and $50.00 for FULL DAY (6:30am - 6:00pm)

CHILD'S NAME: ______________________________________

PARENT/GUARDIAN : ____ ______/______/_____
((SIGNATURE) (DATE)

PROGRAM DIRECTOR : ____ ______/______/_____
((SIGNATURE) (DATE)

PRETTYBOY Recreation Council Registration Form

This Registration Form shall be completed by the participant, or if the participant is a minor/child, by the legal authorized parent or guardian of such minor/child participant.

Enrollment Information:

Participant's Name: ____________________ Date of Birth: ____/____/____ Male: ____ Female: ____

Street Address: ____________________ Home Phone: ____________________

City/State: ____________________ Zip Code: _________ Parent's E-Mail: ____________________

Activity Registering for: Tiny Tots School Attending____________________

Yes, I am interesting in helping: _____ I would like more information: _____

Emergency/Health Issues:

In case of emergency, please notify (if minor/child participant, provide parent's information or Guardian, as appropriate).

Name:____________________ Relationship:______________ Home Phone_________________ Cell Phone____________________

Name:____________________ Relationship:______________ Home Phone_________________ Cell Phone____________________

Physician's Name: ____________________ Physician's Phone: ____________________

Name of Medical Provider: ____________________ Date of last tetanus immunization: ____________________

Any medical, psychological, or behavioral conditions we should be aware of (bee stings, food allergies, etc.)?____________________

1. Are there any medical or health factors or limitations that might affect participant's performance in the activity?
   Yes ___ No ___

2. Is participant taking any medications or have a condition that may affect participant's safety or performance in the activity?
   Yes ___ No ___

3. Is participant required any special accommodations (due to disability) to participate in the activity?
   Yes ___ No ___

If yes, please explain: ____________________

In case of injury or emergency, I for myself and/or participant (if participant is minor/child), and my personal representatives, heirs and assigns, (severally and collectively "I" for this registration form) give permission for an activity representative to call 911 and transport participant to a hospital. I shall inform the Recreation Council, in writing, of any medical or health conditions of participant that occurs or develops and which could affect participant's safety, performance or participation in or throughout the activity.

Signature of participant or, if minor, of parent/guardian: ____________________ Date: ________________

ACKNOWLEDGEMENT, WAIVER AND RELEASE OF LIABILITY:

I hereby confirm participant is in good health and able to participate in the activity. I acknowledge the activity may involve risk and danger of bodily injury or death. I fully accept and acknowledge the activities may involve risk, and I hereby assume the risk and responsibility for all dangers and risks associated with the participant in the activity. I further understand that concussion information is available at www.cdc.gov/concussion .

I acknowledge Baltimore County, Maryland, the recreation council, and their respective employees, directors, officers, volunteers, members and any other participant, entity, party or person involved in any regard with the activity or the activity premises and their respective agents, personal representatives, heirs, employees, contractors, successors and assigns (each on "activity representative" and collectively the "activity representatives"), shall not be responsible or liable in any regard or manner for any and all property damage or bodily injury (including serious physical injury or even death) incurred by participant or any party related thereto as a result of his/her participation in the activity.

I have read, fully understand, and hereby freely sign, approve of, and agree to the terms of this registration form. I hereby unconditionally release, discharge, covenant not to sue, waive my rights and remedies, and agree to hold harmless the activity representatives from any and all claims, costs, demands, losses, damages, or expenses associated with, in whole or in part, participant's involvement with the activity. I certify all answers and information provided on this registration form are to the best of my knowledge true and correct throughout the activity. I shall inform the recreation council in writing if any information provided in this registration form is incorrect or changes through the course of the activity. I understand Baltimore County and/or the recreation council do not perform criminal and/or background checks on activity representatives. I shall present a government-issued photo identification card including, but not limited to, my drivers license, passport, or United States Visa to the activity representative for review, if requested, at the time I submit this registration form to the recreation council.

Signature of Participant (if over 18) OR of parent/guardian (if under 18):____________________ Date: ____________________

Print Name of Signatory: ____________________ Relationship to Participant: ____________________

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
ALL ABOUT: ________________________________
Child's First Name or Nickname

Child's Name: ____________________ Birthdate: ____________

Parent/Guardian: ____________ Home Phone: ____________ Work Phone: ____________

Address: ____________________ Zip Code: ____________

Provider/Center: ____________________ Phone: ____________

Address: ____________________ Zip Code: ____________

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES

MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES

THINGS MY CHILD MIGHT NEED HELP WITH

WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: ______________________________ Date: __________

Provider: ______________________________ Date: __________

Updates:

Parent/Guardian: ____________ Date: ________ Parent/Guardian: ____________ Date: ________

Provider: ______________________ Provider: ______________________

CACFP Enrollment:Yes:___No:___
Meals your child will receive while in care:
BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.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**

Last First Middle Mo / Day / Yr M☐F☐

Address: ______________________

Number Street Apt# City State Zip

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

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name: Address: Phone #	Name: Address: Phone	Physical Exam: Dental Care: Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.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 given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature:______________________________ Date: ______________

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

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

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

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
Lead Test Indicated: DHMH 4620 ☐ Yes ☐ No	**Test #1**	**Test#2**	**Test # 1**	**Test #2**

______________________ **has had a complete physical examination and any concerns have been noted above.**

(Child's Name)

Additional Comments: ____

____

____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME________________________/________________/________________
LAST FIRST MIDDLE

CHILD'S ADDRESS________________________/________________/__________/__________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE_____/_____/_____ PHONE____________________

PARENT OR GUARDIAN________________________/________________/________________
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO

Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO

Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print):____________________**Signature**: ____________________ **Date**: __________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name:________________________ Signature:________________________

Date:________________________ Phone: ________________________

Office Address: ____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print):____________________Signature:____________________Date: __________

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name:________________________ Signature:________________________

Date:________________________ Phone: ________________________

Office Address: ____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

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)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
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

Frederick (Continued)
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

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
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

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 DEPARTMENT OF HEALTH 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
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
______	______	______	______
______	______	______	______
______			

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

1. ____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. ____
Signature Title Date

3. ____
Signature Title Date

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

Clinic / Office Name
Office Address/ Phone Number

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

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 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)

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's (OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary.

COMAR Regulations and other information about the Office of Child Care may be found at:

earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care

HOMEBASE & TINY TOTS

Child's Name_________________________

Parent/Guardian Signature _______________________

Today's Date: _______/________/_______

What are the types of Child Care Facilities?

Family Child Care – care in a provider's home for up to eight (8) children

Large Family Child Care– care in a provider's home for 9-12 children

Child Care Center – non-residential care

Letter of Compliance (LOC) – care in a child care center operated by a religious organization for children who attend their school

All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

Did You Know?

- Regulations that govern child care facilities may be found at: earlychildhood.marylandpublicschools.org/regulations
- The provider's license or registration must be posted in a conspicuous place in the facility;
- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;
- Parents/guardians may visit the facility without prior notification any time their children are present;
- Written permission from parents/guardians is required for children to participate in any and all off property activities;
- All child care facilities must make reasonable accommodations for children with special needs;
- A "Teacher" qualified person must be assigned to each group of children in a child care center;
- Staff:child ratios must be maintained at all times in child care centers;
- Parents/guardian must be immediately notified if children are injured or have an accident in care;
- Child care facilities may have policies beyond regulatory requirements;
- OCC should be notified if a provider has violated child care regulations;
- Parents/guardians may review the public portion of a licensing file; and
- The provider's compliance history may be reviewed on CheckCCMD.org.

For questions, concerns or to file a complaint contact your regional office

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worchester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

Resources

Child Care Subsidy - Assists parents with cost of childcare

1-866-243-8796

Consumer Product Safety Commission (CPSC) - regulates certain products used in childcare

cpsc.org

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org

Larry Hogan, Governor

Karen B. Salmon, Ph.D.
State Superintendent of Schools

OCC 1524 (10/2018)

Guide to Regulated Child Care

Important Information About Child Care Facilities