

Dear KNS Parents, New and Returning:

Thank you for your 2011-2012 school year application! By now you have been advised of your class placement. Please confirm your child's enrollment in KNS by following the registration procedures detailed below.

If you no longer wish to keep the space assigned to your child, please let us know as soon as possible so we may offer it to someone on the wait list. If we have not received your deposit by the deadline of **May 1st**, we will assume you and your child will not be taking the space reserved for you at KNS. However, if you DO want the space but for some reason cannot get your deposit in to us by that date, please let us know.

How this packet is organized:

The checklist on the next page lists all fees and forms due to KNS. A detailed description of each item on the checklist follows. The next section contains key information regarding KNS policies and procedures. The remainder of the packet consists of the forms associated with each item on the checklist.

Please let us know if you have any questions. Welcome to KNS!

The Membership Committee

Christina Lange	cmlange753@yahoo.com
Shara Dahl	shara.dahl@verizonbusiness.com
Rhea Strnad	rheastrnad@yahoo.com
Adriana Heery	adripbf@gmail.com

Key Dates to Keep Handy

May 01, 2011	Deadline for payment of tuition deposit & fees
May 14, 2011	Spring Social
August 01, 2011	Deadline for submission of KNS forms & health forms
August 15, 2011	Deadline for submission of KNS forms & health forms
August 25, 2011	New Member Meeting
August 25, 2011	General Membership Meeting (Mandatory)
August 27, 2011	First Work Day (Mandatory)
September 05, 2011	Kensington Labor Day Parade and Festival
September 12, 2011	First Day of School!

REGISTRATION CHECKLIST

Fees	Due	Frequency	Return To	Completed
Tuition Deposit	May 1 st	yearly	Lange	<input type="checkbox"/>
Education	May 1 st	yearly	Lange	<input type="checkbox"/>
Building & Maintenance	May 1 st	yearly	Lange	<input type="checkbox"/>

KNS Forms	Due	Frequency	Return To	Completed
Membership Survey *	May 1 st	upon admission	Lange	<input type="checkbox"/>
Teacher Information	May 1 st	yearly	Lange	<input type="checkbox"/>
Extended Day	May 1 st	yearly	Lange	<input type="checkbox"/>
Photo Release Form	May 1 st	yearly	Lange	<input type="checkbox"/>
Co-oping Participation	Aug 1 st	yearly	Woodward	<input type="checkbox"/>
Emergency Information	Aug 15 th	yearly	Heery	<input type="checkbox"/>

MD Health Forms	Due	Frequency	Return To	Completed
Medical Report for Child Care *	Aug 15 th	upon admission	Heery	<input type="checkbox"/>
Health Inventory	Aug 15 th	yearly	Heery	<input type="checkbox"/>
Allergy Health Care Plan	Aug 15 th	yearly	Heery	<input type="checkbox"/>
Asthma Action Plan	Aug 15 th	yearly	Heery	<input type="checkbox"/>
Medication Authorization Form	Aug 15 th	yearly	Heery	<input type="checkbox"/>
TB Test	Aug 15 th	every 3 years	Heery	<input type="checkbox"/>
Release of Info – Social Services	Aug 15 th	every 2 years	Heery	<input type="checkbox"/>

*** For new families only; returning families do NOT need to complete these two (2) forms.**

Return payments and forms via the family mailbox at the school or mail directly as follows:

Christina Lange
11409 Dewey Road
Silver Spring, MD 20906
(301) 949-0359
cmlange753@yahoo.com

Ellen Woodward
3510 Perry Avenue
Kensington, MD 20895
(301) 933-2317
ewasilau@yahoo.com

Adriana Heery
3404 May St
Silver Spring, MD, 20906
(240) 669-6966
adripbf@gmail.com

Fees

Tuition Deposit

One tuition installment, equal to one-tenth of the annual tuition, for each child enrolling at KNS is payable as a non-refundable fee. The remaining nine installments will be due by the first of each month from September through May. Please note that there is a **10%** discount for younger siblings attending in the same school year.

Class	Annual Tuition	Installment	10% Sibling Discount
AM 2s (2 days)	1,120.00	112.00	100.80
PM 2/3s (2 days)	1,120.00	112.00	100.80
AM 3s (3 days)	1,420.00	142.00	127.80
PM 3/4s (3 days)	1,420.00	142.00	127.80
AM 4s (5 days)	2,000.00	200.00	180.00

Education Fee

A non-refundable education fee of **\$20.00** is required for expenses associated with one or two parent education seminars conducted at the school each year and to bring enrichment programs to the school for our students. Only one education fee is required per family.

Building and Maintenance Fee

A non-refundable building and maintenance fee of **\$100.00** is required for maintenance expenses, such as repairing the roof, or purchasing mulch for the playground. The fee is split into a \$40.00 tax-deductible building fee and a \$60.00 non-deductible maintenance fee. Only one building and maintenance fee is required per family.

Scholarship Guidelines

KNS may be able to provide financial assistance to families to enroll or to keep their child at school. Requests should be in the form of a letter to the treasurer explaining the general circumstances, the amount needed, and how many months' assistance may be needed. The identity of applicants will be kept confidential. The Treasurer, President and Ombudsman will make the decision about awarding scholarships. Guidelines for scholarship determination are available in the Treasurer's mailbox. The Treasurer will keep a written record of the request and any action therein in the files. There will be no repayment or extra work required in return for assistance.

Payment Details

The tuition deposit (for each child), education fee, and building & maintenance fee must all be received by May 1st. Please note that you may forward one check to cover all three fees:

- \$ 232.00 if your child will be in the AM 2s or PM 2/3s class
- \$ 262.00 if your child will be in the AM 3s or PM 3/4s class
- \$ 320.00 if your child will be in the AM 4s class

KNS Forms

Membership Survey

This survey helps us understand where special talents lie within the membership base, and is used to determine family job assignments. Please take extra time with this form as we need to know what you can and would like to do for the school.

Teacher Information Form

This form helps the Director and teachers get to know your child in advance of the start of the school year. This form is confidential and can also be mailed directly to the Director, Helene Segal-Turner (4801 Broad Brook Court, Bethesda, MD 20814). Please note on the outside of the envelope the class your child will be attending.

Extended Day Registration Form (optional)

Extended Day is offered Monday, Wednesday and Friday from 11:30am - 2:00 pm for students enrolled in the AM 3 and AM 4 classes. Refer to the form for additional details about signing up for this option or contact the Treasurer for more details.

Photo Release Form

Indicate on this form whether or not you give KNS permission to have your child or family photo(s) used in KNS materials (newsletter, website, marketing).

Co-oping Participation Form

This form is vital to the smooth functioning of the school. Each family is expected to co-op in the classroom. How often a family co-ops depends on the number of children in the class and the number of days per week the class meets. **A parent is required to fulfill at least 50% of the family co-oping responsibility in the classroom.** It is very important for your child that you participate in his/her classroom experience. Nannies, au pairs, babysitters or relatives may fulfill the other half of the family co-ping duties provided they have a TB test on file with the school.

KNS offers an option of sharing babysitting with other KNS families. A list is posted at the beginning of the year for those interested. It is your responsibility to arrange for babysitting. If you are interested in sharing babysitting while co-oping, please indicate so on this form.

Emergency Information Form

This form is kept on file at the school and is also taken on field trips. Please be sure to fill out both pages. It is very important to keep this form updated throughout the school year and from year to year. Returning families can initial the form at the Mandatory Membership meeting in August (instead of submitting another form), if nothing has changed. The Emergency Form **MUST** be completed (or updated) by the start of school (09/12/11); your child will not be allowed to participate in school until the form is completed.

MD Health Forms

Completion of these forms is mandated by the State in order for KNS to maintain its license.

NOTE: It is important to meet the **August 15th** deadline for the submission of these forms. The Health & Safety officer must have sufficient time to review and process forms before the start of the school year. If completed and accurate forms are not received by the first day of school (09/12/11), your child will not be permitted to attend school and a \$50 fee will be assessed.

Medical Report For Child Care

The Maryland Department of Human Resources, Child Care Administration now requires all adults assisting at the preschool to get a physical checkup from their health care provider. This requirement ensures you are able to perform the essential functions of the co-oping job, including lifting young children, getting up and down from the floor, participating in lively outdoor activities and moving furniture.

Health Inventory Form

This form (4 pages) is required for all private nursery schools licensed by the Department of Human Resources Child Care Administration. Your child's health care provider must fill out this form and sign it. The Health Inventory Form does NOT have to be completed in conjunction with a child's annual check-up; a health care provider can fill out these forms any time.

Your child will not be permitted to attend school unless his/her immunizations are up to date, appropriate to age. If your child is too young to receive the fourth or fifth DPT booster shots, have your pediatrician fill out the half-page form and explain when the booster will be given.

All children under the age of six (6) must provide evidence of lead testing to enroll in preschool. Your health care provider should sign this form.

NOTE: Even if a family does NOT live in a zip code area that requires testing, the health care provider still needs to sign the form.

KNS will accept health forms provided by the health care provider as long as the information requested in the Health Inventory Form is supplied on those forms. Please make sure the health care provider signs the form; then staple it to the Health Inventory Form for submission.

Allergy Health Care Plan, Asthma Action Plan, Medication Authorization Form

Complete if applicable. A table with student allergy information will be posted in each classroom and on the kitchen cabinet where the medicine is kept.

TB Test

All co-oping adults must have a TB test and chest X-ray (if indicated) before they may participate in the classroom. Proof of the test should be returned with the other health forms. TB tests are given at the Montgomery County Health Centers for a nominal charge. Montgomery County Resources for TB Testing are listed here:

<http://www.montgomerycountymd.gov/content/hhs/phs/tbEnglish%20Resources.pdf>

Please note that anyone co-oping for you must also have a TB test on file. This includes nannies, au pairs, baby-sitters, grandparents, etc. Results can be noted on the Medical Report for Child Care form or reported by the Testing Facility itself; KNS does not provide a form for the test results. **The TB test is valid for 3 years.**

Release of Information: Social Services

The Maryland Department of Education, Office of Child Care, requires permission from parents of KNS children to review, if necessary, records of child or adult abuse or neglect in the possession of the State or Local Department of Social Services. This form needs to be NOTARIZED. **This form is valid for two years.**

Key Information

Home Visit

In an effort to facilitate the school transition, your child's classroom teacher will schedule a home visit prior to the start of the school year. The teacher will contact you in July or August to arrange a mutually convenient time.

Tuition

Payments are due on the first of each month, starting in September. The final payment is due May 1, 2012. Monthly tuition payments are used to pay teacher salaries at the end of each month; making prompt payment of tuition from the families very important. Payments received five (5) days late must include a \$5.00 penalty and after ten (10) days late, must include a \$10.00 penalty. If a family has not paid tuition by the end of the month, the child will not be able to return to school until the payment has been made. However, consideration is always given to personal financial difficulties. In this case, the Treasurer should be informed. A scholarship fund may be available. During the school year, tuition may be mailed to the Treasurer or placed in the box in the entrance hall of the school. Payment by semester is an option for any family finding this more convenient. There is a 10% discount for siblings enrolled simultaneously. Please see scholarship guidelines on 2011-2012 Acceptance and Confirmation (financial obligation) form.

<u>CLASS</u>	<u>TUITION</u>
AM 2s (2 days a week)	\$ 112.00/month
PM 2/3s (2 days a week)	\$ 112.00/month
AM 3s (3 days a week)	\$ 142.00/month
PM 3/4s (3 days a week)	\$ 142.00/month
AM 4s (5 days a week)	\$ 200.00/month

Maintenance Hours

Each family is required to fulfill a minimum of six (6) maintenance hours working at the school. There are three workdays per year. If you are unable to work on these dates, the Maintenance Committee will announce ongoing projects throughout the year and can be contacted at any time to provide information on other ways to earn credit. A family may buy out no more than half of their maintenance hours at a rate of \$50/hr, if they desire. At the end of the school year, a fee will be assessed for each unearned maintenance hour.

Fundraising Hours

Fundraising is an important element in a cooperative school. KNS is, above all else, a group effort. Part of the work we do to keep the tuition down and the school alive and well functions on fundraising. Each family is obligated to earn at least six (6) fundraising hours. A family may buy out no more than half of their fundraising hours at a rate of \$50/hour, if they desire. At the end of the school year, a fee will be assessed for each unearned fundraising hour.

School Job

In addition to the requirements listed above, each family must assume one job, which contributes to the overall function of the school. KNS members may hold a Board position, or sign-up to work for either the committee of their choice or the committee to which they are assigned by the Jobs Coordinator.

Board Positions

President (2 yr position)
Vice-President
Treasurer (2 yr position)
Secretary
Communications Chair
Membership Chair
Fundraising Co-Chairs
Participation Chair
Maintenance Chair

Committees

Social and Community Outreach
Participation
Fundraising
Maintenance
Communications
Membership

Substitute Co-ops

You are responsible for arranging for a substitute co-oper when you are unable to co-op on a certain day. You may switch co-oping duties with another family or arrange for an approved paid co-oper to take your place. The Co-op Participation Chairperson will assign each family to a participation group. Should you be unable to arrange a substitute, you are responsible for notifying your participation group that you need to stay at home that day. This is necessary to maintain the proper adult-child ratio in the classroom. This will be further explained at the August Membership meeting.

Siblings

Each family at KNS has a certain responsibility at the school. One responsibility that is of utmost importance to parent, child and teacher is that of co-oping. This is a time when the parent's fullest attention is required in the class. Therefore, SIBLINGS MUST NOT ATTEND ANY CLASS, unless enrolled in said class. If you wish to swap babysitting duties with another KNS family while co-oping, indicate so on the Co-oping Participation Form. We want your experience at KNS to be an enjoyable one for you and your child(ren). By providing your complete attention to your co-oping duties, you will help make it a wonderful experience for everyone involved.

Community Outreach

The Social and Community Outreach Committee oversees the KNS involvement in the Town of Kensington's Labor Day Parade and various other events. These events offer a great way for KNS families to get to know each other. The Community Outreach Committee will contact you with more information regarding the traditional Labor Day Parade in Kensington. Please sign up (during the August Membership meeting) to help us with the parade. You can also help share our school's spirit by marching with us on Labor Day and helping at our school's booth during the festival!

Kensington Nursery School is a parent owned and parent operated school. Our accomplishments in any given year are strictly and totally determined by the talents and efforts of our individual assets. This survey will help us know where you can best make your contribution.

Child's Last Name, First Name (Class)
Child's Last Name, First Name (Class)
Child's Last Name, First Name (Class)

Parent/Guardian Last Name, First Name

Phone (best number to reach you)

Email

Please mark one:

- I am a full-time stay-at-home parent
- I am a stay-at-home parent and work part-time from home
- I am a stay-at-home parent and work part-time outside the home
- I work full-time from home
- I work full-time outside the home
- Other (please describe)

What is your current or most recent occupation?

Parent/Guardian Last Name, First Name

Phone (best number to reach you)

Email

Please mark one:

- I am a full-time stay-at-home parent
- I am a stay-at-home parent and work part-time from home
- I am a stay-at-home parent and work part-time outside the home
- I work full-time from home
- I work full-time outside the home
- Other (please describe)

What is your current or most recent occupation?

Please mark **all** that apply to the parent(s)/guardian(s):

ADMINISTRATIVE SKILLS

- I have advanced word processing or spreadsheet experience
- I have experience in computer graphics and design
- I have database experience (build, create, maintain, edit, report generation, etc.)
- I have experience in creating, editing or maintaining websites
- I have access to a copy machine at no cost

FUNDRAISING EXPERIENCE

- I have formal fundraising skills (non-profit, capital campaign, sorority)
- I have informal fundraising skills (KNS, church, elementary school, scouts)

Describe:

MAINTENANCE EXPERIENCE

- Carpentry (indicate basic, intermediate, or advanced skills)
- Plumbing (indicate basic, intermediate, or advanced skills)
- Electrical (indicate basic, intermediate, or advanced skills)
- I own or have access to:

- Pickup Truck
- Van
- Snowplow
- Wood Chipper

I can recommend the following service professionals (carpenters, plumbers, electricians, landscapers, etc.):

OTHER SKILLS/TALENTS

- Instrumental/Voice
- Acting/Performance
- Arts and Crafts
- Sewing/Knitting
- Baking/Cooking
- Photography
- Calligraphy
- Foreign Language
- Other (describe)
- Would you be willing to share your talents in the classroom?

Thank you for letting us get to know your family better!



Teacher Information Form

(Confidential - seen only by teacher to help get to know child & family)

Child's Name/Class _____

Child's Name/Class	
Sex (mark "M" or "F")	
Address	

Nickname	
Birth Date	
Phone Number	

Parent/Guardian Name	
Education	
Occupation	

Age	
Interests	

Parent/Guardian Name	
Education	
Occupation	

Age	
Interests	

Siblings (Names & Ages)	
Family Interests	

Particular family circumstances (divorced, extended family living with you, step-siblings who are involved with the child, full-time nanny, etc.)

Recent or upcoming changes in child's life (moving, divorce, acquisition or loss of pet, new baby, etc.)

Allergies (esp. food), disabilities, or other medical history that may affect the child's school experience

Family Pets

Type of dwelling you live in (include whether or not you have a yard)

Do both parents have opportunities to spend time with child?

Does child have a good relationship with mother/parent/guardian? (yes or no, describe if you wish)

Does child have a good relationship with father/parent/guardian? (yes or no, describe if you wish)

Does child separate easily from parents?

Does child have babysitters?		Frequency?	
Does child have neighborhood playmates?		Frequency?	
Formal playgroup?		Frequency?	
Does your child play well alone?		Prefer to play alone?	



Teacher Information Form

(Confidential - seen only by teacher to help get to know child & family)

Child's Name/Class _____

Has child had previous school experience? _____

Major reason for sending child to nursery school _____

Has parent had previous co-op experience? _____

Major reason for choosing a co-op _____

Any concerns about adjustment? _____

What types of play does child enjoy? _____

Does your child like to be read to? Like to get dirty?

How much TV does child watch in a day? What programs? _____

What type of discipline has been most effective (please give examples)? _____

What types of positive reinforcement work best for your child (please give examples)? _____

Do parents agree on how to handle child? _____

Does child accept discipline easily? _____

Does child bite nails? Wet bed? Suck thumb? Cry often?

Does child have any particular fears? Did something cause this? _____

Has child been toilet trained? If so, when? Can child completely care for self at toilet? _____

How much can child dress self? _____

At what age did child walk alone? Use words? Use sentences?

Does child have any speech difficulty or physical difficulty (please describe)? _____



Teacher Information Form

(Confidential - seen only by teacher to help get to know child & family)

Child's Name/Class _____

How does child display anger?

Is child physically affectionate?

How does child react to new situations?

Does child defend self? How?

Does child verbalize feelings easily?

Is child shy around other children? Around adults?

What five (5) words best describe this child's personality?

Additional Comments

The Extended Day Program is an unstructured class experience open to children enrolled in either the AM 3 or the AM 4 classes at KNS. Extended Day is offered on Monday, Wednesday and Friday afternoons. It begins when the morning classes end at **11:30am and runs until 2:00pm. The cost is \$20 per day.** You may register your child for one **or** two out of the three days. There is a paid assistant so no co-oping is necessary.

Extended Day is similar to a class in that you register in advance to guarantee a space for your child for the entire year; you also pay for the entire month whether or not your child attends. Monthly payments vary throughout the year. Extended Day tuition is based on the day(s) in which your child is enrolled, and the number of Mondays, Wednesdays and Fridays vary each month. An Extended Day tuition table will be posted prior to the beginning of school.

Enrollment in Extended Day is for the year. If you decide to withdraw your child from Extended Day during the school year while maintaining your class enrollment (AM3 or AM4), you will be financially responsible for the Extended Day slot until it is filled by another child.

Child's Name	
KNS Class Enrolled	
Parent/Guardian Phone #	

Day(s) Requested	Number preferences 1 st , 2 nd , 3 rd
Monday Only	
Wednesday Only	
Friday Only	
Monday & Wednesday	
Monday & Friday	
Wednesday & Friday	

I understand that by registering my child for Extended Day, I am financially responsible for the slot for the entire year:

<i>Signature of Parent/Guardian</i>	<i>Date</i>
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I, , parent/guardian of preschool student,

Consent

Do Not Consent

to the use of photographs made of my child and/or members of my family during preschool events and/or activities, for the purposes of the newsletter, website or other marketing materials for KNS. Photos used on the KNS website will not have names listed with them. The monthly newsletter is posted on the password-protected portion of the KNS website, with names and captions removed from beneath the photos.

Further, I release KNS from any liability which may arise from the use of those materials. This release will remain in full force and effect until withdrawn in writing by me or at the end of the calendar school year.

If you accept these terms and conditions please mark the box "Consent", sign below and return the form to Membership.

If you do not accept these terms and conditions please check the box "Do Not Consent", sign below and return the form to Membership.

Parent/Guardian Signature:

Date:

Child's Class: (Please mark one)

AM 2	<input type="checkbox"/>
PM 2/3	<input type="checkbox"/>
AM 3	<input type="checkbox"/>
PM 3/4	<input type="checkbox"/>
AM 4	<input type="checkbox"/>

All co-ops must read the KNS Handbook, when it is distributed, and be familiar with school policy.

Child's Name (Last Name, First Name)	
Class	
Parent's Name	
Phone Number	

The participation chairpersons will try to honor individual scheduling preferences as indicated below. There must be two co-ops in the classroom on each day, so please be as flexible as possible when selecting your co-oping preferences below. You may indicate days in order of preference. Please indicate only the days your child attends school, i.e. AM 2s is Tuesday & Thursday. For AM 3s & AM 4s, you may have to co-op on days in which your child has extended day. For AM 4s, please try to designate at least **three** options for days to co-op. Co-oping schedules are issued bi-monthly.

Monday		Thursday	
Tuesday		Friday	
Wednesday		No Preference	

If you are available to co-op as a paid substitute for **\$10/hour**, mark below:

For my child's class	
For any class	

Mark here if you would like to "baby-swap" while co-oping. Your name and number will be shared with other parents interested in trading child-care.

Mark here if you are interested in carpooling. Your name and number will be added to the carpool list posted at the beginning of the school year.

Please list any questions you have regarding participation at KNS and the participation chair will respond with a call or via email. Thank you!

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EMERGENCY FORM

Child's Name (last, first)

Child's Class

ALLERGIES

Home Phone #

Parent Cell Phone #

Parent Cell Phone #

PARENT/GUARDIAN

Name (Last, First)

Address (Street)

Employer/School

Home Phone #

Address (City, St, Zip)

Work Phone #

PARENT/GUARDIAN

Name (Last, First)

Address (Street)

Employer/School

Home Phone #

Address (City, St, Zip)

Work Phone #

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency (in the order they should be contacted):

#1

Name (Last, First)

Relationship to Child

Home Phone #

Cell Phone #

Work Phone #

#2

Name (Last, First)

Relationship to Child

Home Phone #

Cell Phone #

Work Phone #

#3

Name (Last, First)

Relationship to Child

Home Phone #

Cell Phone #

Work Phone #

HEALTH CARE PROVIDER

Address (Street)

Phone #

Address (City, St, Zip)

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 childcare facility to have your child transported to that hospital.

Printed Name

--

Signature

--

Date

--



EMERGENCY FORM

Child's Name (last, first)

Child's Class

ALLERGIES

Home Phone #

Parent's Cell Phone #

Parent's Cell Phone #

MEDICAL CONDITIONS

Please list any medical conditions

Medications currently being taken by the child

Date of child's last tetanus shot

Allergies/Reactions

EMERGENCY MEDICAL INSTRUCTIONS

Signs/Symptoms to look for

If Signs/Symptoms appear, DO THIS

To prevent incidents, do this

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED

--

Did you complete an Allergy Health Care Plan? _____

Did you complete an Asthma Action Plan? _____

Did you complete a Medication Authorization Form? _____

If necessary, have the child's health care provider review the information you provided above and sign/date where indicated below.

Name of Health Care Provider		Phone #	
Signature of Health Care Provider		Date	

ANNUAL UPDATES

(initials/date)

(child class, birth date)

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICAL REPORT FOR CHILD CARE

Name of Person being evaluated: _____ Date of Birth: _____

Name of Child Care Applicant/Provider/Facility: _____

Address of Facility: _____

Dear Health Practitioner:

The person to be evaluated either provides (or plans to provide) child care services or lives in a home where family child care is (or will be) given.

1) **RESTRICTED OR REQUIRE SPECIAL CONDITIONS** from contact with children in care due to having any of the following:

a) Communicable disease: _____

b) Chronic medical condition or physical impairment: _____

c) Vision/Hearing/Speech Disorder: _____

d) Nervous or Emotional Disorder: _____

e) Drug or Alcohol Abuse: _____

f) Immunization status: _____

2) Tuberculosis Screening: (if needed or required by the Local Health Officer.)

Type of test: _____ Results: _____ Date: _____

Answer question 3 if the person being evaluated provides (or plans to provide) child care services:

Persons who provide child care services must be able to participate fully in a program for active young children. This includes lifting infants and young children, getting up and down from the floor, lively outdoor activities, and moving furniture. It may also include transporting children in a motor vehicle.

3) Describe medical limitation(s) or medication(s) the person is taking, that may impair the person's ability to perform care-related activities, such as the ones noted above.

Signature of Physician, CNP, RPA

Date

Phone Number

STAMP, PRINT, OR TYPE: Name and Address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____	_____	_____	_____	_____
_____	Last	First	Middle	Birth Date
Name of Parent or Guardian _____	_____	_____	_____	_____
_____	_____	_____	_____	Relationship
Home Address _____	_____	_____	_____	_____
City _____	State _____	Zip Code _____	_____	_____
Check Best Telephone Number to Reach You:				
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____	<input type="checkbox"/> Cell #: _____	_____	_____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

City/Town State Zip Code

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN**

CHILD'S NAME: _____

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (<i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i>)?	_____	_____
2. Does your child have any eye problems (<i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i>)? Date of last eye examination: ____/____/____ Doctor's Name: _____ Results: _____ Does your child wear glasses? _____ Contact lenses? _____	_____	_____
3. Does your child have any ear or hearing problems (<i>frequent earaches, difficulty hearing, etc.</i>)? Date of last hearing evaluation ____/____/____ Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	_____	_____
4. Does your child have any speech problems (<i>difficulty having speech understood, stammering, delayed speech development, etc.</i>)?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: (a) Does this condition require any special health care in the child care facility? _____ (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? _____ (c) Does your child require any special adaptations or adaptive equipment? _____	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

REMARKS (*Provide further explanation for all "YES" answers*): _____

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: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ___ Positive ___ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS) _____
- a. Vision problem YES NO _____
 - b. Hearing problem YES NO _____
 - c. Speech or language problem YES NO _____
 - d. Other physical illness or impairment YES NO _____
 - e. Mental, emotional or behavior problems YES NO _____
 - f. Developmental delays YES NO _____
 - g. Allergies YES NO _____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO
 If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.
 YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO
 If YES, please specify: _____

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

8. Does this child's physical activity need to be restricted? YES NO
 If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO
 If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO
 If YES, please specify type: _____
 Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a permanent temporary condition until ____/____/____. Check appropriate box, indicate vaccine(s) and reasons: _____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care. (circle correct response)

Signature of Health Practitioner

Date

Phone Number

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

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



MARYLAND DEPARTMENT OF
HEALTH AND
MENTAL HYGIENE

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

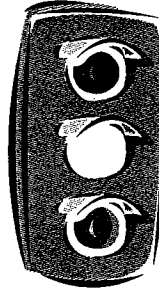


Maryland Chapter

ASTHMA ACTION PLAN

Check Asthma Severity: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: _____
Personal Peak Flow Ranges

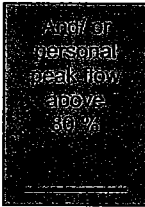
RED means Danger Zone!
Get help from a doctor. _____

YELLOW means Caution
Zone! Add prescribed yellow
medicine. _____

GREEN means Go Zone!
Use preventive medicine. _____

GO (Green) → Use these medications every day.

- You have all of these:
- Breathing is good.
 - No cough or wheeze.
 - Sleep through the night.
 - Can work and play.



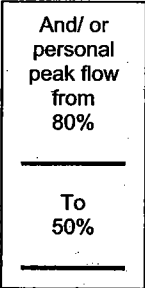
Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

--	--	--

CAUTION (Yellow) → Continue with green zone medicine and ADD:

- You have any of these:
- First sign of a cold.
 - Exposure to a known trigger.
 - Cough.
 - Mild wheeze.
 - Tight chest.
 - Cough at night.



Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

YOUR ASTHMA IS GETTING WORSE FAST

- Your asthma is getting worse fast:
- Medicine is not helping within 15-20 minutes.
 - Breathing is hard and fast.
 - Nose opens wide.
 - Ribs show.
 - Lips are blue.
 - Fingernails are blue.
 - Trouble walking or talking.



Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room.
DO NOT WAIT.

- Trigger List:**
- Chalk dust
 - Cigarette smoke
 - Colds/Flu
 - Dust or dust mites
 - Stuffed animals
 - Carpet
 - Exercise
 - Mold
 - Ozone alert days
 - Pests
 - Pets
 - Plants, flowers, cut grass, pollen
 - Strong odors, perfume, cleaning products
 - Sudden temperature change
 - Wood smoke
 - Foods:
 - _____
 - _____
 - Other:
 - _____

**MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICATION AUTHORIZATION FORM**

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions with prior written permission (Section A) from the child's parent/guardian. A separate form is needed for each prescription or non-prescription medication to be administered to the child.

PRESCRIPTION MEDICATIONS AND NON-PRESCRIPTION MEDICATIONS: Prescription medications must be in a container labeled by the pharmacy or physician with the child's name, dosage, and expiration date. At least one dose of prescription medication must be given at home prior to the child's arrival at the child care facility. **Non-prescription** medications must be in the original manufacturer's container labeled with instructions for dosage and expiration date. Except for acetaminophen (Tylenol) and other topical medications, a provider may administer only one dose of non-prescription medication to a child per illness unless a licensed health practitioner provides written approval (Section B) for the administration of the non-prescription medication and the dosage. All medication shall be administered according to the instructions on the label of the medication container or a licensed health practitioner's written instructions, whichever are more recently dated. **An adult should bring the medication to the center/provider.**

Name of Child: _____ Date of Birth: _____ Age: _____

A: (To be completed by parent/guardian for any medication to be administered to the child.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
I/We request that designated child care providers/or staff administer medication as noted on this form. I/We certify that I/We have legal authority to consent to medical treatment for the child named above, including administration of medication while in child care. I/We understand that at the end of the year or if the medication is discontinued or expired, an adult must pick up the medication, otherwise it will be discarded.				
Signature of Parent/Guardian: _____			Date: _____	

SECTION B: (To be completed by the Health Practitioner for approval to administer non-prescription medication more than one dose per illness, other than acetaminophen (Tylenol) or other topical medication.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
ADDITIONAL INSTRUCTIONS:				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
Health Practitioner's Signature: _____			te: _____	
Print, Type or Stamp: Name, Address, Phone number and Title of Health Practitioner:				

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
RELEASE OF INFORMATION – Child Care

Child Care regulations require signed and notarized permission to examine records of child and adult abuse and neglect for information about:

- 1) The applicant/operator (if the applicant/operator is an individual) or family day care provider;
- 2) Each child care center employee or staff member;
- 3) Each adult, 18 years old or older, living on the premises of the child care facility or applicant;
- 4) Each family day care substitute;
- 5) Each family day care additional adult;
- 6) Each trustee, manager, and board member, who may have frequent contact with children in care, if the applicant/operator is a corporation, agency, association, or other organizational entity; and
- 7) Any other individual identified by the Office.

STATEMENT OF PERMISSION

I hereby authorize the OCC to have access to any files or records of child and adult abuse or neglect in the possession of a State or Local Department of Social Services in order to help OCC:

- Evaluate my suitability for employment in or by a child care center, **or**
- Determine whether to approve the issuance or maintenance of an initial or continuing license, letter of compliance or registration for: _____, located at:
(Name of Applicant/Operator, or Licensed, Letter of Compliance or Registered Child Care Facility)

Street Town/City State Zip Code

Furthermore, I understand that the information obtained by OCC from the State or Local Department of Social Services may provide grounds for OCC to:

- Prohibit or require termination of my employment at the child care center, **or**
- Deny, suspend, or revoke the license, letter of compliance, registration or application of the Child Care Center, Family Child Care Provider or Applicant/Operator named above.

If I am not the Applicant/Operator or Provider, I authorize OCC to release this information to an authorized representative of the Child Care Center, or to the Family Child Care Provider or the Applicant/Operator.

Signature and Date

Print Name (First, Middle, Maiden, and Last)

Address: Street City State Zip Code

Telephone Number Social Security Number

Date of Birth Position: Employee, Resident, Substitute, Volunteer, etc.

Male Female Primary Language Spoken: _____

Race (check all that apply): American Indian or Alaskan Native
 Asian Black or African American Native Hawaiian or Pacific Islander
 White Other (specify): _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Notary