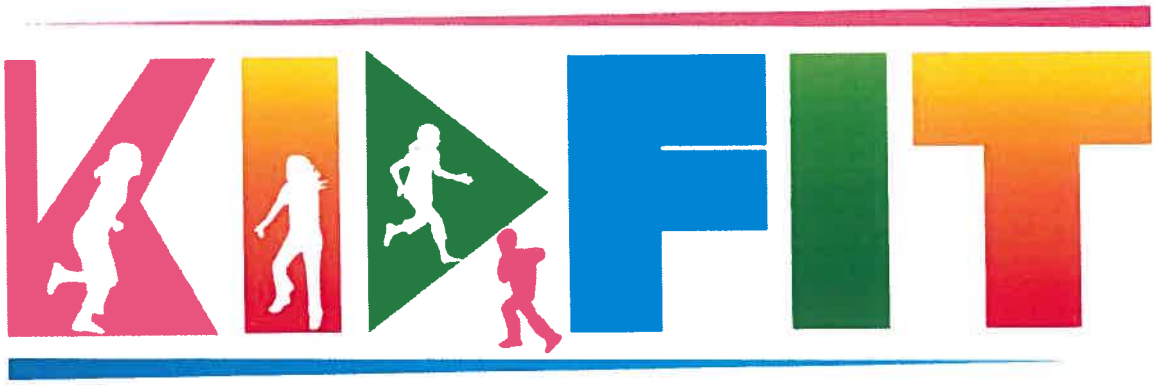

KidFit Virtual Learning
School Year 2020-2021
5010 Brown Station Road, #195
Upper Marlboro, Maryland 20772
240.510.3622

HOURS OF OPERATION:

Morning Program...7:00am – 6:00pm
Afternoon Program...Bus Drop-Off until 6:30pm

ENROLLMENT FORMS: All enrollment forms must be filled out completely and returned to our office before your child may begin the program. These forms include a registration/emergency form and health information. New forms must be filled out each year. You are responsible to notify the program immediately of any changes on this form.

SIGN IN/SIGN OUT: All children must be signed in and/or out by a parent/guardian or authorized person each day. Parents must come into the building to drop off or pick up their child. Please make sure staff is aware of your child's arrival and departure. No child can be released from the program to any other person other than his or her parent or a person currently designated in writing by such parent who is pre-authorized for pick up on the registration form. We must be notified in writing if another adult will be picking them up who is not listed. For safety purposes, photo identification will be required for all persons picking up children. We reserve the right to not allow any child to leave the building with anyone we believe to be under the influence of a substance, which would impair his or her ability to safely transport or care for a child.

ABSENTEE/ILLNESS: If your child is going to be absent, please call our office at 210.510.3622 as soon as possible. It is your responsibility to notify us if your child is going to be absent.

Your child's health is important to all of us. In order to keep our program a healthy place for children and staff, we must help prevent the spread of contagious illness. Please consider how you would feel if your child was exposed to other children who are ill when considering whether you should keep your ill child home or make alternate arrangements. When in doubt, please call us. Children cannot attend the program if they are ill or injured. They should be able to fully participate in the program. If your child becomes sick while at the program, you will be asked to pick him/her up immediately in order to prevent the spread of illness. Children should be free of an elevated temperature (100 or higher) at least 24 hours before returning to the program regardless of the reason. Following an illness, children should not return until they can resume normal activities. We may require a doctor's note before allowing a child to return to the program. This policy is not all-inclusive, and we reserve the right to send a child home for any health-related concerns.

INCLEMENT WEATHER/SCHOOL CLOSINGS: Our center will try our best to accommodate you during inclement weather and school closings. We will provide you with the information ahead of time.

PERSONAL ITEMS: Our staff will not be responsible for personal items brought to the program. Please label your child's items in case they are left behind. We reserve the rights to prohibit certain toys, electronics, etc., we feel are causing a disruption to the program. If you are concerned about your child's clothing, please send a smock for craft time. We cannot assume responsibility for damaged clothing.

Fees

Registration Fee: $60.00 per child
Program Fee: $170.00
Kids Returning from 2019/2020 B/Aftercare & Summer Camp will be granted a slight discount

Please Check Appropriate Care Needed

NO CREDITS OR REFUNDS WILL BE GIVEN

We accept the following payment methods:
Money Order
Credit Card
Checks payable to: GirlFit Workout Studio.
No Cash Accepted On-Site

Payment is due the first day of the week…NO EXCEPTIONS
Payments are not prorated nor reduced based on your child attendance. _____(Please initial)
We require a 2-week written notice prior to withdrawing your child. _____(Please initial)

Non-payment of tuition is grounds for immediate dismissal from the program. Timely payments are essential for continued enrollment in the KidFit Program; however, if you anticipate difficulty with paying on time, please discuss the matter with the Director immediately. If alternative arrangements for payment are approved you will be notified by the Director.

PLEASE WRITE "N/A" IF NOT APPLICABLE ☐ Child/Children Information (Same Family)

Name:	Gender:	Date of Birth:
School:	Grade:	
Name:	Gender:	Date of Birth:
School:	Grade:	

PARENT/LEGAL GUARDIAN INFORMATION

Mother's Name:	Father's Name:
Address:	Address:
City:	State/Zip Code
Home/Cell:	Home/Cell:
Work:	Work:
Email:	Email:
Place of Employment	Place of Employment
Authorized to Pick Up Child: Yes or No	Authorized to Pick Up Child: Yes or No

Provide us with anyone you may give permission to pick up your child at any time or notify if parents cannot be reached:

Name	Address	Relationship	Phone #

HEALTH INFORMATION

MEDICATION POLICY: A parent or guardian will be called to pick up a child who is sick or injured. Medicine will not be administered without written permission from the parent or legal guardian.

PLEASE PROVIDE US WITH ANY MEDICAL INFORMATION PERTAINING TO YOUR CHILD WHICH WE SHOULD BE AWARE OF (food restrictions, activity restrictions, allergic reactions & special medications, special needs, disabilities, etc.)

_____

_____

_____

_____

EMERGENCY/MEDICAL INFORMATION

I, _____, parent/guardian of _____
(Date of birth)_____ do hereby give my permission and/or consent to the KidFit Program to secure and authorize such emergency medical care and/or treatment as my child (above named) might require while under the supervision of said KidFit Program staff. I also authorize said KidFit Program staff to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

I understand every effort will be made to notify parents IMMEDIATELY in case of emergency.
Physician

Physician Name:	Phone#
Address:	

WAIVER/BEFORE AND AFTER SCHOOL AGREEMENT

Waiver/Policy must be read and signed before registration is accepted. I assume all risks and hazards incidental to the conduct of the above-mentioned program(s) and do hereby further release and hold harmless the KidFit Program staff. I give permission to a licensed physician or hospital staff to administer emergency medical care deemed necessary for myself when normal permission is unavailable. I certify that my child or I are in good physical health and have no limitations other than those I have listed, which may predispose my child or I to risk during this program. I also fully realize that I must provide proper hospitalization. KidFit does not provide insurance coverage. I have read and understood the Refund Policy. Photo Release: I understand that photos may be taken of participants during the activity. These photos will become the property KidFit and may be used to promote the program. Before and After School Agreement: I have read the policies of the program and I agree to abide by such terms. The information on this form is accurate. I have provided all of the necessary information to properly care for my children.

Only person/s signing this form are authorized and responsible to make any change of information.

Parent/Guardian Signature:_____

Date: _____

Discipline Policy

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, GirlFit Aftercare Program uses a positive approach to discipline and practices the following discipline and behavior management techniques.

WE DO

- Communicate to children using positive statements.
- Communicate with children on their level.
- Talk with children in a calm quiet manner.
- Explain unacceptable behavior to children.
- Give attention to children for positive behavior.
- Praise and encourage the children.
- Reason with and set limits for the children.
- Apply rules consistently.
- Model appropriate behavior.
- Set up the classroom environment to prevent problems.
- Provide alternatives and redirect children to acceptable activity.
- Give children opportunities to make choices and solve problems.
- Help children talk out problems and think of solutions.
- Listen to children and respect the children's needs, desires and feelings.
- Provide appropriate words to help solve conflicts.
- Use storybooks and discussion to work through common conflicts.

WE DO NOT

- Inflict corporal punishment in any manner upon a child. (Corporal punishment is defined as the use of physical force to the body as a discipline measure. Physical force to the body includes, but is not limited to, spanking, hitting, shaking, biting, pinching, pushing, pulling, or slapping.)
- Use any strategy that hurts, shames, or belittles a child.
- Use any strategy that threatens, intimidates, or forces a child.
- Use food as a form of reward or punishment.
- Use or withhold physical activity as a punishment.
- Shame or punish a child if a bathroom accident occurs.
- Embarrass any child in front of others.
- Compare children.
- Place children in a locked and/or dark room.
- Leave any child alone, unattended or without supervision.
- Allow discipline of a child by other children.
- Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary problems occur. If a child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.

My signature below indicates that I have received a copy of the discipline policy, it has been received by me, and I have read and understand this policy.

Signature_____ Date_____

Child_____

Financial Agreement

Child's Name _____ Age_____

Parent's Name_____

I _____, agree to the following payment policies, in order to have my child(ren) enrolled in KidFit.

I agree to pay the weekly tuition fee $_____ and any other fees in full, every Monday, prior to leaving my child at the center. I understand that payment is due every Monday regardless if my child is ill or the program is closed for holiday. Furthermore, I understand that once tuition is paid there are no refunds and that payment should be made by check, money order, credit card, cash app, Paypal or debit. If tuition is not paid on time (by close of business on Monday) a $5.00 late fee per day will be charged; and my child(ren) will be unable to return unless past due tuition and late charges are paid. Late fees also apply to debit card and credit card payments that are returned. GirlFit Summer Program charges a $35.00 fee on all returned checks. Furthermore, the returned check and fees must be paid by money order, credit or debit by within 48 hours of notification. If two returned checks are accepted by the center, I understand the center will be unable to accept more of my personal checks.

I understand that the centers hours of operation are Monday through Friday 7:00am -6:00pm. Should I pick my child up after 6:15pm I agree to pay a late fee of $15.00 for each 15 minutes or fraction thereof after 6:15 in which my child remains at the center. I understand that late pick-up fees are due at the time I pick up my child(ren) or before returning to the center.

I understand that my failure to do so could result in legal action if deemed necessary. Parents will be liable for all collection cost in addition to all outstanding fees, including 2 weeks charge if proper notice is not given.

I understand if my account becomes delinquent more than (3) three times, my child will be terminated from the program.

I have read this financial agreement and agree to its term. Furthermore I understand failure to follow this agreement could result in the termination of childcare for my child(ren)

_____ _____

Parent/Guardian Signature Date

KidFit COVID-19 UPDATES AND SAFETY PRECAUTIONS

As the global pandemic of COVID-19 continues, KidFit will be taking great measures in ensuring the safety of our students and community are priority. KidFit values the safety and wellbeing of its staff, children and families. KidFit has taken steps to implement new policies/procedures within our center to ensure we are further preventing the spread on COVID-19. By closely monitoring all updates, our priority is to comply with CDC guidelines We are closely monitoring the changing situation and complying with the CDC and MSDE guidelines.

Vulnerable/High Risk Groups: It is recommended that individuals at higher risk for severe illness from COVID-19 consult with their medical provider to assess their risk and determine if they should stay home if there is an outbreak in their community. Parents should consult with a health care professional before enrolling their child. Staff and parents ages 65 or older are highly encouraged to consult with their medical provider before coming to the center.

Preventative Health Measures:

KidFit will follow all applicable regulations from CDC and MSDE daily.

Promoting Healthy Hygiene Practices; Effective immediately:

• All students and staff must sanitize hands upon entering the building and every hour after until the child is picked up from the center.

• All staff and students must answer a COVID-19 screening daily before entering the building.

• We expect all parents to be honest while answering the COVID-19 screening questionnaire.

• If a parent is shown to be dishonest, KidFit has the right not to accept their child.

• Any international travelers will be prohibited from KidFit.

• Staff or students that have been around anyone with COVID-19 will be prohibited.

• Staff or students who have any COVID-19 symptoms and do not have a doctor's note to justify symptoms will be prohibited.

• All students and staff must get their temperature taken prior to entering the building. Any student or staff with a temperature of 100.4 or higher (the set temperature is based on CDC and MSDE) will be not be allowed to enter the center and will not be able to return unless a doctor's note is provided.

• All students and staff ages 3-up must wear a face mask throughout the day expect during lunch, snack, and nap times. Any student without their face mask will not be allowed in the center. Any student or staff who do not follow the guidelines of keeping their face mask on will not be able to stay in the center.

• Parents are responsible for making sure all students have an adequate amount of face masks and the proper face masks.

• Any student or staff who have medical conditions (such as asthma or other breathing conditions) are not required to wear a face mask as long as the doctor provides the center a note.

• All soap and hand sanitizer in the building will have at least 60 percent alcohol.

• Signs on how to stop the spread of COVID-19 will be posted in all classes and throughout the building.

• After every use, the teacher will disinfect frequently touched surfaces (including but not limited to door knobs, keyboards, games, toys, bathrooms, etc.).

• All class sizes will now be 1 teacher to 10 students.

• Students must pack their breakfast snack, lunch, and afternoon snacks.

• Non-essential visitors and volunteers are prohibited during this time

• All children belongings will be separate.

• If a child must bring additional items, including a change of clothes, all items must be in a labeled Ziploc bag or storage container.

• All supplies such as art supplies, sports equipment, etc. will be limited to a small group of children at time. Students will rotate times using equipment so that all supplies can be disinfected after each use.

• No refunds will be given to any parents for any reason.

• No credits will be able to sit on accounts for more than the month your child will be in attendance.

• If someone in our center is positively diagnosed with COVID-19, the center will have to shut down for 2 weeks and no refunds will be given.

• KidFit will not be open for drop in care.

Signature: _____ Date: _____

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	Name:	Physical Exam:
Address:	Address:	Dental Care:
Phone #	Phone	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				
LeadTest 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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

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

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: _____ Date: _____

OCCP 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.
(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