BAC Parent contract 2022-2023

Child's Full Name_____ **Date of Birth**_____ **Age** _____

Address_____ **City**_____ **State**_____ **Zip**_____

School_____ **Grade**_____

Please initial beside the selected program

	Guardian's Initials	
Before School		$70/week
Before School w/transportation		$90/week
After School		$75/week
After School w/transportation		$100/week
Before & After School		$105/week
Before & After School w/transportation		$155/week

A registration fee of $35 per child will be charged on the date of enrollment using the payment method provided.

***School Days Out/Closing Policy*:**

- Please check our Facebook page, website or WBOC during inclement weather for delayed opening or closings.
- When schools are closed for the day, Crown Care children may attend our *School Days Out & Snow Days Off* program at a DISCOUNTED RATE. The additional cost is:

  Full Day Child Care for child/ren attending Before **AND** After Care: $15 per day, or $10 for ½ days
  Full Day Child Care for child/ren attending in Before **OR** After Care: $25 per day, or $20 for ½ days

  ** Sibling discounts are not available for School Days Out or Snow Days Off

Payment Policy

- Full tuition payments are required regardless of your child's attendance. There will be NO financial refund/credit of tuition including but not limited to emergency closings, weather related closings, illness, holiday closings, suspensions/expulsions, unexpected withdrawal (for any reason) and/or family vacations. If your child is out of the center for an extended time (more than 2 weeks) due to illness/hospitalization, those cases will be addressed individually by the Center Director.
- Tuition payments are **due on Monday** of the week of care. Parents are required to participate in our Tuition Express program through Procare program which will automatically deduct the tuition from your checking account, savings account, or credit card (3% fee applied). Payments returned or rejected for uncollected and/or insufficient funds will be assessed a $35 fee, in addition to any bank charges. Uncollected payments, including fees, must be satisfied before your child may return to care.
- If early contract termination and/or a change to the contract is required, parent/guardian must complete and submit a **WITHDRAW/CHANGE REQUEST FORM** to Crown Care giving 30 days advance notice. The thirty-day advance notice will begin the date the WITHDRAW/CARE CHANGE REQUEST form is SUBMITTED to the Crown Care Director. If proper notice is not given prior to withdrawal, parent/guardian WILL BE RESPONSIBLE FOR THE FULL TUITION PAYMENT for the next 30 days.
- Contract will remain in effect for the entire school year, including Christmas and Easter break.

I understand and agree to the "Payment Policy" stated above
Initial _____

Sibling Discount:

- A sibling discount will be issued when siblings contract for Crown Care. Discount is applied at the rate $10 per week after one full price tuition. Each sibling must be registered for both Before **AND** After Care.

Refund Policy:

- Refunds will be issued only when the prepaid amount exceeds the thirty-day written withdraw notice. Debit or Credit card payments disputed and/or reversed will be subject to all applicable interest and fees including but not limited to late fees.

I understand and agree to the "Refund Policy" stated above
Initial _____

Late Pickup Policy:

- Crown Care closes at 5:30pm. If you are late picking up your child, a late fee will be assessed at the rate of one dollar, $1, for each minute you are late. This fee will be assessed according to our clocks and payment is due when you pick up your child. Your child will not be allowed to return to care until the fee is paid in full.

I understand and agree to the "Late Pickup Policy" stated above
Initial _____

Personal Belongings:

- Child/ren should not bring personal items or electronics. Crown Sports Center/Crown Care will not be held responsible for lost, stolen or damaged items (example: I- pads, hand-held video games, cell phones, clothing, storage containers, books, toys, lunch and/or drink containers, etc.).

I understand and agree to the "Personal Belongings" stated above
Initial _____

Conduct and Discipline:

- Crown Sports Center/Crown Care are committed to providing a safe and positive environment for all children. To ensure this, children and parents are expected to immediately report any personal offenses or threatening situations to Crown Care staff and/or Director. The Code of Conduct is included in Crown Care packet so that children and their families are informed of the behavior expected of all participants for the safety, health and happiness of the participants and staff.
  Disciplinary Measures May Include: verbal warning, time out, loss of special event privileges, phone call to parent, parent conference, suspension and/or immediate dismissal without a refund.

I understand and agree to the "Conduct and Discipline" stated above
Initial _____

Crown Sports Center reserves the right to cancel this contract at any time, without prior notice. **Initial** ____

By signing below, I acknowledge that I have received a copy of the **Crown Care**

Parent Handbook and **Consumer Pamphlet.** I understand and agree to follow

the Crown Care policies, Procedures, terms, and conditions listed

I have read, understand and agree to all the policy terms and conditions listed in

this Crown Care Contract.

Child's Name:

_____

Signature of Parent/Legal Guardian _____

Printed Name:_____Date _____

Child's Name_____ Email Address_____

Do you receive a childcare subsidy from the State of Maryland? YES NO

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience, and ease of Tuition Express®—a payment processing system that allowssecure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize The Crown Center to initiate credit cardcharges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbersfor automatic payments. Check with the center for accepted credit card types.

COMPLETE <u>ONE</u> SECTION ONLY

SECTION A (Credit Card) ***By using a credit card, a <u>3%</u> will be charged to your account.***

Cardholder Name Phone #

Cardholder Address City State Zip

Account Number Expiration Date

Cardholder Signature Date

SECTION B (Bank Account/ACH draft)

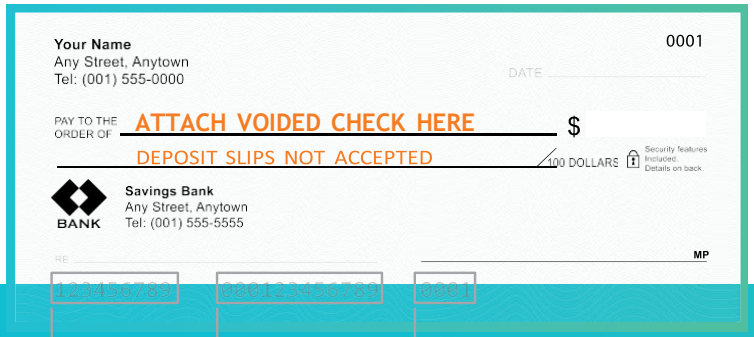
Your Name Phone #

Address City State Zip

Bank or Credit Union Name Bank or Credit Union Address City State Zip

Routing Transit Number (see sample below) Account Number (see sample below) ☐ Checking ☐ Savings

Authorized Signature **Date**



<u>A $35.00 NSF fee will be charged for any returned payments.</u>

_____

_____ (hereinafter referred to as the/my "Child")
Child's Name

EMERGENCY TREATMENT AUTHORIZATION

I, _____, am the undersigned Parent/Guardian. I expressly acknowledge and agree by signing this Emergency Treatment Authorization (this "Authorization") I authorize the officers, directors, members, managers, Agents, representatives, employees and volunteers of Crown Center, LLC (d/b/a "Crown Care") (hereinafter "Crown Care") To act for me (the undersigned Parent/Guardian) according to their respective best judgement in the event of a medical emergency and/or routine medical care involving the Child. By signing this Authorization, I hereby expressly waive, release and hold harmless Crown Care and all its officers, directors, members, managers, agents, representatives, employees and volunteers from any and all liability for: (a) any injury(ies), death or illness(es) sustained and/or incurred by the Child while he/she is attending any Childcare Program(s) administered or provided by Crown Care; (ii) using any facility(ides) maintained and/or managed by Crown Care., including, any facilities comprising or being a part of "Crown Center," located at 28410 Crown Road, Fruitland, MD 21826, or (iii) participating in any activity(ies) or program(s) provided, Managed or operated by Crown Care or otherwise performed or conducted at Crown Center. By my execution of this Authorization, I expressly grant permission to all officers, directors, members, managers, agents, representatives, employees and/or volunteers of Crown Care, any paramedic, or emergency services rescue squad, or any private physician and/or staff of a hospital or emergency health care facility, to provide or otherwise administer emergency medical treatment and/or routine medical care for my child, if such person(s) deem necessary. In the case of an emergency involving your Child which requires immediate attention, the Child will be taken to the nearest hospital emergency room. Your signature below authorizes a representative of Crown Care to have the Child transported to such hospital emergency room. Any such action will be taken in the best interest of the Child and will be reported to the undersigned Parent/Guardian soon as possible. By executing this Authorization, I expressly waive and release Crown Center, LLC (d/b/a "Crown Center"), and all officers, directors, members, managers, agents, representatives, employees and volunteers from any and all liability, claims, damages, and/or financial responsibility of any kind whatsoever, including, but not limited to any medical expenses incurred for medical treatment provided to the Child, which arise from any matter(s) relating to or in connection with the Child's participation or enrollment in any program(s) and/or activity(ies) managed, provided or administered by Crown Center or otherwise conducted or performed at Crown Center.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

ILLNESS

In the event the Child becomes ill during his/her participation in any Childcare Program administered or managed by Crown Care, You will be contacted by a Crown Care representative as soon as possible. If You cannot be reached, Crown will notify the Child's emergency contact regarding the Child's illness. It's Your responsibility to arrange for the Child to be picked-up from the Crown Center premises as soon as possible. In the event the Child or anyone in the immediate household of the Child develops or is otherwise diagnosed with a reportable communicable disease as defined by the State Board of Health, You must notify Crown Care within 24-hours or the next business day in order for the proper action to be taken, except in the case of life- threatening diseases which You must report immediately to Crown Care.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

_____
Child's Name

MEDICATION

Only medication prescribed by a Physician will be administered to Child. If the Child needs to take medication during Crown Care program hours, a Medication Authorization Form must be completed. The Medication Authorization Form includes space for Crown Care staff to record administration of the medicine. Do not send medications with the Child. Medicine must be provided to a Crown Care staff member by the Child's Parent/Guardian. All medicines will be kept by Crown Care staff in the designated, locked medicine box. Children are not permitted to keep medications on their person or in their book bags, lunch box, cubby, or pockets.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

ALL PRESCRIPTION MEDICATIONS SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCITONS FOR ADMINISTRATRION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. WE CANNOT ACCCEPT MEDICATION AUTHORIZATION FORMS FROM THE CHILD'S SCHOOL OR OTHER PROGRAMS-ONLY THE CROWN FORMS INCLUDED IN THIS PACKET.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

PROGRAM ENROLLMENT AGREEMENT

Carefully read and sign below:

I understand that my child will not be released to any person(s) not listed on the enrollment form. In case of an emergency, an emergency plan will be followed.

- I understand that my child will not be released to any person(s) who seem(s) to be under the influence of drugs or alcohol.
- I understand that my child must be signed in and/or out daily by myself or my designee
- If my child is experiencing problems in the program a conference will be arranged between the parent, staff and/or Program Director/Coordinator.
- Crown Care reserves the right to terminate services if it is determined the placement is unsatisfactory.
- All information provided at the time of enrollment is complete and accurate.
- False or incomplete information may lead to termination of services.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

_____

Child's Name

PARTICIPATION WAIVER

I, II understand that Crown Center, LLC (d/b/a "Crown Care") ("**Crown Care**") and each and every of its officers, directors, members, managers, agents, representatives, insurers, assigns, attorneys, contractors, parents, subsidiaries, successors, affiliates, principals, employees and volunteers (each a "**Releasee**", and collectively the "**Releasees**"), assumes no responsibility whatsoever for any injury or illness, of any kind, any athletic activity, sports program, child daycare program, sports class, arcade activity, roller skating activity, laser tag activity, the use of any equipment or in the performance of any exercise or activity administered or provided by Crown Care or conducted at the Crown Center facilities located at 28410 Crown Road, Fruitland, Maryland 21826 (collectively the "**Released Activities**"). By my execution of this Participation Waiver, I expressly acknowledge on behalf of myself, my spouse, the Child and all of my successors, heirs, representatives and assigns (collectively the "**Releasors**"), that I assume all risk for any and all injuries and illness which may be sustained or otherwise suffered by the Child arising from which may result from his/her participation in any of the Released Activities and, furthermore, I hereby release and discharge the Releasees from any and all claims of injury, illness, death, loss or damage which my child my suffer or sustain as a result of his/her participation in any o f the Released Activities. I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS EACH AND EVERY OF THE RELEASEES FROM ANY AND ALL LIABILITY, CLAIMS, DEMANDS, LOSSES AND/OR DAMAGES SUFFERED BY OR ON ACCOUNT OF MY CHILD WHICH MAY BE CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE ACTS OR OMMISSIONS OF ANY RELEASEE(S), INCLUDING ANY RESCUE OPERATION(S) CONDUCTED, OVERSEEN OR MANAGED BY ANY RELEASEE(S), REGARDLESS OF NEGLIGENCE OR THEABSENCE THEREOF ON TH EPART OF ANY RELEASEE. I FURTHER EXPRESSLY ACKNOWLEDGE AND AGREE: IF, DESPITE THIS RELEASE AND THE TERMS OF THE AGREEMENT SET FORTH HEREINABOVE, THE CHILD (AS IDENTIFIED ABOVE), OR ANY PERSON(S) ACTING ON BEHALF OF SUCH CHILD, MAKES A CLAIM AGAINST ANY RELEASEE(S), I, AT MY SOLE COST AND EXPENSE, SHALL INDEMNIFY, SAVE AND HOLD HARMLESS EACH AND EVERY OF THE RELEASEES FROM ANY AND ALL LITIGATION EXPENSES, ATTORNEY FEES, LOSS, LIABILITY, DAMAGE, OR COST ANY RELEASEE(S) MAY INCUR AS A RESULT OF ANY SUCH CLAIM. I EXPRESSLY ACKNOWLEDGE AND AGREE THE CHILD IDENTIFIED HEREIN ABOVE SHALL BE DEEMED AND OTHERWISE CONSTRUED TO CONSTITUTE A "RELEASOR" OF THE RELEASEES; NOT WITHSTANDING ANY TERM TO THE CONTRARY SET FORTH IN THIS "PARTICIPATION WAIVER,"

IN THE EVENT OF ANY CONFLICT BETWEEN THE TERMS OF THIS "PARTICIPATION WAIVER" AND ANY OF THE TERMS CONTAINED ELSEWHERE IN THIS CROWN CARE REGISTRATION PACKET, THER TERMS CONTAINED IN THIS PARTICIPATION WAIVER SHALL GOVERN THE UNDERSIGNED MINOR'S PARENT AND/OR LEGAL GUARDIAN, THE CHILD IDENTIFIED HEREINABOVE, AND ALL RELEASEES (AS DEFINED HEREINABOVE) WITH RESPECT TO ANY AND ALL MATTERS REFERENCED IN THIS PARTICIPATION WAIVER. I recognize that Crown care will make every reasonable effort to minimize exposure to known risks associated with the Childcare Program(s) managed and provided by Crown Care. I understand that whether Crown Care is not, nor is any other Releasee, responsible for any personal property which becomes lost, stolen, or destroyed while Childcare Program participants are using the Crown Center facilities. I hereby expressly permit and authorize Crown Care to use, without limitation or obligation, photographs and/or film footage of my child's image or voice for purpose of promoting or interpreting Crown Care programs. BY MY EXECUTION OF THIS PARTICIPATION WAIVER, I, ON HEHALF OF MYSELF AND ALL RELEASORS, EXPRESSLY ACKNOWLEDGE AND AGREE: I HAVE READ THIS PARTICIPATION WAIVER, I FULLY UNDERSTAND ALL TERMS CONTAINED HEREIN, I FULLY UNDERSTAND THAT I, ON BEHALF OF MYSELF AND ALL REALSORS, HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING THIS PARTICIPATION WAIVER, AND I HAVE SIGNED THIS PARTICIPATION WAIVER FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE, AND I INTEND THIS PARTICIPATION WAIVER TO BE A COMPLETE AND UNCONDITIONAL RELAEASE OF THE REALEASEES OF AND FROM ANY AND ALL LIABILITY OF ANY KIND WHATSOEVER, TO THE GREATEST EXTENT ALLOWED BY LAW.

SIGNATURE OF PARENT/GUARDIAN _____**DATE**_____

PRINTED NAME OF PARENT/GUARDIAN _____**DATE**_____

_____
Child's Name

REGULARLY SCHEDULED OUTINGS

PERMISSION SLIP

My Child _____ has my permission to participate in the activities listed below transported by Crown Center, LLC (d/b/a "Crown Care") staff to the following activities and places:

1. Arcade located inside of Crown Sports Center
2. Roller skating located inside of Crown Sports Center
3. Rock Wall located inside of Crown Sports Center
4. Crown Room located inside of Crown Sports Center
5. Outdoor sport fields located at the North end of Crown Sports Center
6. Outdoor woods located at North of the outdoor fields
7. All five (5) indoor soccer fields and sprots court

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

PERMISSION TO TRANSPORT FORM

I (Parent/Guardian Printed Name) _____ authorize Crown Center, LLC (d/b/a "Crown Care") to transport my child (Child's Name) _____ to and from (Name of Child's School) _____ as well as field trips, special events and in the event of any emergency, weather or biohazard etc., that may occur during the 2022-2023 school year.

Parent Signature: _____ Date: _____

Parent Printed Name: _____

_____
Child's Name

ENROLLMENT MEDICAL NEEDS

Does your child have any health concerns such as:

Allergies	YES	NO	Medication required _____
Asthma	YES	NO	Medication required _____
Diabetes	YES	NO	Medication required _____
Seizures	YES	NO	Medication required _____
Other	_____		Medication required _____

If you have circled YES to any of these concerns, you will need to complete an action plan. You may obtain the form from our website, office, or health packet.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

SUNSCREEN and INSECT REPELLENT POLICY

Parent Permission Form

Camp Crown does not provide sunscreen or insect repellent for participants.

- Sunscreen/insect repellent should be applied in the morning before your child arrives at Camp Crown.
- Sunscreen/insect repellent should be in the original container only.
- Sunscreen/insect repellent must be clearly labeled with the child's name.
- Sunscreen/insect repellent will be stored in camper's classroom.
- Please make sure the sunscreen/insect repellent you provide has been used previously on your child with no adverse reactions.
- School age students will reapply their own sunscreen before outdoor activities, if needed.
- If your child should require assistance applying sunscreen/insect repellent, you must give permission below.
- Please make sure that you purchase clear spray sunscreen.
- Under No Circumstances are campers allowed to apply sunscreen/ insect repellent to another camper.

☐ I authorize the staff at Camp Crown/Crown Center, LLC to apply sunscreen/insect repellent to my child.

☐ Do not apply sunscreen/insect repellent to my child. This means that you do not want counselors to help with the application of sunscreen.

Signature of Parent/Guardian _____ Date _____

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

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Larry Hogan, Governor

Mohammed Choudhury
State Superintendent of Schools

OCC 1524 (10/2018)

Guide to Regulated Child Care

Important Information About Child Care Facilities

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

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.

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** 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:

CROWN
SPORTS CENTER

By signing below, I acknowledge that I have received a copy of the **Crown Care Parent Handbook** and **Consumer Pamphlet.** I understand and agree to follow the Crown Care policies, Procedures, terms and conditions listed.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:___ No:____

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

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

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

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

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

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____Date _____

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete.*

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 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_____

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	_____	DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				_____	_____	_____	_____	
5	DOSE #5								_____	_____	_____	_____	

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)