CROWN CARE CONTRACT

BEFORE & AFTER SCHOOL PROGRAM 2024-2025

Child's Full Name_____ Birthdate_____ Age_____

Mom's Name_____Phone #_____

Mom's Email Address_____

Dad's Name_____ Phone #_____

Dad's Email Address_____

Please sign beside the selected program:

Before School	$90/week	Signature:
Before School w/ Transportation	$105/week	Signature:
After School	$95/week	Signature:
After School w/ Transportation	$120/week	Signature:
Before & After School	$120/week	Signature:
Before & After w/ Transportation	$170/week	Signature:
Home School Half Day		Signature:
Home School Full Day		Signature:
Aspiring Athletes Add-On: This is an additional fee for sports training	$30/week	Signature:

A registration fee of $50/child will be charged upon receipt of this contract.

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 Camps at a discounted rate. The additional cost will be as follows:

  School Days Out Camps for child(ren) attending Before **AND** After Care: $15/full day, $10/half day

  School Days Out Camps for child(ren) attending Before **OR** After Care: $25/full day, $20/half day

Payment Policy:

* Full tuition payments are required regardless of the 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, suspension/expulsions, unexpected withdrawals and/or family vacations.

* Tuition payments are due on the Friday before your child attends. Parents are required to participate in our Tuition Express Program through Procare 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 Withdrawal/ Change Request Form to Crown Care giving 30 days advance notice. The thirty day advance notice will begin the date the Withdrawal/ Care Change request form is submitted to the Crown Care Director. If prior 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.

* The undersigned promises to pay all costs of collections(40%), including but not limited to court costs, attorney fees(15%), of any amount due and owing.

I understand and agree to "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.

Late Pick-Up 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 $2 for each minute you are late. This fee will be assessed according to our clocks and your account will be billed on the next business day.

I understand and agree to "Late Pick-Up Policy" stated above. Initial_____

Personal Belongings Policy:

* Child(ren) should not bring personal items/electronics to Crown Care. Crown Care/Crown Center LLC will not be held responsible for lost, stolen, or damaged items (example: I-pads, Phones, Watches, etc)

I understand and agree to "Late Pick-Up Policy" stated above. Initial_____

Conduct and Discipline Policy:

* Crown Care/Crown Center LLC 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 Director. The Code of Conduct is included in the Crown Care handbook 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, phone call to parents, parent conference, suspension and/or immediate dismissal without a refund.

I understand and agree to "Conduct and Discipline Policy" stated above. Initial_____

Crown Care reserves the right to cancel this contract at any time with or without prior notice. Initial_____

By signing below, I acknowledge that I have received a copy of the Crown Care Parent Handbook, Consumer Pamphlet and Parent's Guide to Regulated/Licensed Child Care. I understand and agree to follow the Crown Care Policies and Procedures listed in this contract and in the handbook.

Child's Name_____

Signature of Parent/Legal Guardian_____

Parent/Legal Guardians Printed Name:_____

Date_____

CROWN
SPORTS CENTER

_____ (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**_____

CROWN
SPORTS CENTER

_____
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**_____

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_____

Child's Name

PARTICIPATION WAIVER

I, understand that Crown Center, LLC (d/b/a "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, Clip n Climb 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 of 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. Clip n Climb located inside of Crown Sports Center
3. Crown Room located inside of Crown Sports Center
4. Outdoor sport fields located at the North end of Crown Sports Center
5. Outdoor woods located at North of the outdoor fields
6. All indoor fields and sports 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 2024-2025 school year.

Parent Signature: _____ **Date:** _____

Parent Printed Name: _____

CROWN
SPORTS CENTER

_____
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** _____

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				
Lead Test Indicated: DHMH 4620 ☐ Yes ☐ No	Test #1	Test#2	Test # 1	Test #2

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

(Child's Name)

Additional Comments: _____

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

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

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

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

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

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

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

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

Comments:

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

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

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

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

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

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

MARYLAND 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													
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.

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)

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>

_____