

# Child Development Center

## Enrollment Forms



**JC Dolphins**

2 Years Old

**Creative Investigators**

3-5 Years Old





**Children's File Checklist**

Child's Name: \_\_\_\_\_

Please place forms in order of list:

Enrollment Date: \_\_\_\_\_

- Enrollment form with copy of Wor-Wic Community College class schedule (OCC 1214) Wor-Wic Community College
- Application for Child Care
- Emergency Contact Form
- Health Inventory Form: Part I & II (OCC 1215), Medication Authorization (OCC 1216) Parent/Guardian
- Consent Form (Handbook, Parent's Guide to Regulated Child Care, Photo, Allergy, Communicable Disease Summary)
- USDA Food Program CACFP
- Food Program Child Care Enrollment Form
- Include copy of IEP \_\_\_\_\_ or IFSP \_\_\_\_\_

Entered by staff: \_\_\_\_\_

ProCare Windows:

- Basic Information
- Contacts
- Schedule
- Medical
- Consent forms

Comments:

Copy of the following to Teachers:

- Emergency Form
- Authorized Pickup
- Misc( Any court orders or medical information)



# CHILD DEVELOPMENT CENTER REGISTRATION FORM FOR CURRENTLY ENROLLED CHILDREN

Student ID Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Year: \_\_\_\_\_

Parent Name: \_\_\_\_\_  
Last
First
Middle

- Fall
  - Fall I
  - Fall II
  - Spring
  - Spring I
  - Spring II
  - Summer
  - Summer I
  - Summer II
  - Update/Change
- Date: \_\_\_\_\_

Child(ren)'s Name: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
Last
First
Middle

Telephone: \_\_\_\_\_  
Home or cell
Work

**COST PER BLOCK:**    Student (\$34)       Employee (\$38)       Community (\$165 per week)

**Daytime Hours:**      Minimum of three full days per week/ Community Full-time only

	Day	Number of Blocks	Time	# of Children	# of weeks (circle)	Blocks (x) Children
<b>2 YEAR OLDS (MONDAY – FRIDAY)</b>						
<input type="checkbox"/>	Monday & Wednesday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	
<input type="checkbox"/>	Tuesday & Thursday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	
<input type="checkbox"/>	Friday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	
<b>3 -5 YEAR OLDS (MONDAY – FRIDAY)</b>						
<input type="checkbox"/>	Monday & Wednesday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	
<input type="checkbox"/>	Tuesday & Thursday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	
<input type="checkbox"/>	Friday	2	7:30 – 5:00 p.m.	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6   8   14   16	

## WITHDRAWAL POLICY:

**UPON SIGNATURE, PARENTS OR GUARDIANS AGREE AND UNDERSTAND THE FOLLOWING:**

Effective immediately, the Wor-Wic Community College Child Development Center administration requires a **minimum** of two weeks notice before withdrawing a child. If proper notice for withdrawal is not given, then parents will be charged for the two weeks. Please note that if the last two weeks tuition is not paid, then this charge will be attached to your college bill and grades will not be released until the bill is paid.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### Application for Child Care

Child's First & Last Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Race: Caucasian  African-American  Asian  Hispanic Native American Other

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother/Guardian First & Last Name \_\_\_\_\_ Pager/Cell \_\_\_\_\_  
Employer & Address \_\_\_\_\_ Phone (w) \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_ Phone (h) \_\_\_\_\_  
Email: \_\_\_\_\_

Father/Guardian First & Last Name \_\_\_\_\_ Pager/Cell \_\_\_\_\_  
Employer & Address \_\_\_\_\_ Phone (w) \_\_\_\_\_  
Address (if different than child's) \_\_\_\_\_ Phone (h) \_\_\_\_\_  
Email: \_\_\_\_\_

**Please select the age-appropriate room desired for the child listed above:**

2 years old  3-5 years old

SCHEDULE OF SESSIONS (Please indicate the sessions that are needed.)

7:30 a.m. to 5:00 p.m.	<input type="checkbox"/> Monday/Wednesday	<input type="checkbox"/> Tuesday/Thursday	<input type="checkbox"/> Friday
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Wor-Wic Community College students requesting childcare services must be registered for classes and have their schedule of classes attached in order to receive first preference.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Director Approval \_\_\_\_\_ Date \_\_\_\_\_

**CHILD CARE REGISTRATION IS CONTINGENT UPON RECEIPT OF ALL REQUIRED COMPLETED ENROLLMENT FORMS**

See the "Child Development Center Policies and Procedures Manual for Parents" for all our policies

A CHILD MAY NOT START AT THE CENTER UNTIL THE DIRECTOR APPROVES THE APPLICATION.

**To secure your child a registered space, a non-refundable deposit of one week tuition plus material fee is required.**

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:	W:
			H:	Employer:
		Email:	C:	W:
			H:	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 \_\_\_\_\_

**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: \_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

# HEALTH INVENTORY

## Information and Instructions for Parents/Guardians

### REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered, or approved child care or nursery school:

- **A physical examination** by a health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 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: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

### EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

### INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

**PART I - HEALTH ASSESSMENT**  
**To be completed by parent or guardian**

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b>
Last		First		Middle	
_____			Mo / Day / Yr		M <input type="checkbox"/> F <input type="checkbox"/>
<b>Address:</b>					
Number		Street		Apt#	City
_____		_____		_____	State
_____		_____		_____	Zip
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>	<b>Phone Number(s)</b>		
_____		_____	W: _____	C: _____	H: _____
_____		_____	W: _____	C: _____	H: _____
<b>Medical Care Provider</b>	<b>Health Care Specialist</b>	<b>Dental Care Provider</b>	<b>Health Insurance</b>	<b>Last Time Child Seen for</b>	
<b>Name:</b>	<b>Name:</b>	<b>Name:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Physical Exam:</b>	
<b>Address:</b>	<b>Address:</b>	<b>Address:</b>	<b>Child Care Scholarship</b>	<b>Dental Care:</b>	
<b>Phone:</b>	<b>Phone:</b>	<b>Phone:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specialist:</b>	
<b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.					
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b>					
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
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.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
Printed Name and Signature of Parent/Guardian _____					Date _____



**PART II - CHILD HEALTH ASSESSMENT**  
To be completed **ONLY** by Health Care Provider

<b>Child's Name:</b>	<b>Birth Date:</b>	<b>Sex</b>
Last                      First                      Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?  
 No     Yes, describe:

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2. Does the child receive care from a Health Care Specialist/Consultant?  
 No     Yes, describe

---

3. 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:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:			

**REMARKS:** (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. 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).**  
<https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

7. Should there be any restriction of physical activity in child care?  
 No     Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?  
 No     Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 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: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.)

10. **RECORD OF LEAD TESTING** - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: \_\_\_\_\_

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: \_\_\_\_\_  
LAST
FIRST
MI

SEX: MALE  FEMALE  BIRTHDATE: \_\_\_\_\_  
MM/DD/YYYY

PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

**Health care provider or school health professional or designee only:** To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Name</span> <span>Title</span> </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Signature</span> <span>Date</span> </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"><b>Clinic/Office Name, Address, Phone</b></div> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
2. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Name</span> <span>Title</span> </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Signature</span> <span>Date</span> </div>	

**Health care provider:** Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

- Yes  No  1. Does the child live in or regularly visits a house/building built before 1978?
- Yes  No  2. Has the child ever lived outside the United States or recently arrived from a foreign country?
- Yes  No  3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
- Yes  No  4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
- Yes  No  5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
- Yes  No  6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
- Yes  No  7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

**Provider:** If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. \_\_\_\_\_  
Provider Initial

**Parent/Guardian:** I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

\_\_\_\_\_  
Parent/Guardian Signature
Date

# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

## How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

## Frequently Asked Questions

### **1. Who should be tested for lead?**

All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

### **2. What is the blood lead reference value, and how is it interpreted?**

Maryland follows the [CDC blood lead reference value](#), which is 3.5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ). However, there is no safe level of lead in children.

### **3. If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

Yes, if a capillary test shows a blood lead level of  $\geq 3.5 \mu\text{g}/\text{dL}$ , a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See [Table 1](#) (CDC) for the recommended schedule.

### **4. What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (<https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm>).

### **5. What programs or resources are available to families with a child with lead exposure?**

Maryland and local jurisdictions have programs for families with a child exposed to lead:

- Maryland Home Visiting Services for Children with Lead Poisoning
- Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: <https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx>.

Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention: <https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx>

Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.

Phone: (610) 519-3478 or Toll Free: (833) 362-2243

Website: <https://www1.villanova.edu/university/nursing/macche.html>

**MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_  
 LAST FIRST MI  
 SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_  
 PARENT NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 OR  
 GUARDIAN 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									
5	DOSE #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: \_\_\_\_\_

## 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](http://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](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

**Maryland State Department of Education  
Office of Child Care  
Medication Administration Authorization Form**

Place Child's  
Picture Here  
(optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**  
**This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.**  
**Non-prescription/OTC medication must be in the original container with the label intact per COMAR.**

**PRESCRIBER'S AUTHORIZATION**

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If PRN, for what symptoms, how often and how long \_\_\_\_\_

Possible side effects and special instructions: \_\_\_\_\_

Known Food or Drug Allergies:  Yes  No If yes, please explain: \_\_\_\_\_

For School Age children only: The child may self-carry this medication:  Yes  No

The child may self-administer this medication:  Yes  No

PRESCRIBER'S NAME/TITLE	Place Stamp Here (Optional)
TELEPHONE	FAX
ADDRESS	

**PRESCRIBER'S SIGNATURE** (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

**PARENT/GUARDIAN AUTHORIZATION**

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer**  Yes  No

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
---------------------------	-------------------	--

CELL PHONE #	HOME PHONE #	WORK PHONE #
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**CHILD CARE STAFF USE ONLY**

Child Care Responsibilities:	1. Medication named above was received. Expiration date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Medication labeled as required by COMAR. <input type="checkbox"/> Yes <input type="checkbox"/> No 3. OCC 1214 Emergency Form updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 4. OCC 1215 Health Inventory updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No	
------------------------------	---	--

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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## Consent Form

### Parent Handbook, Photo Release, Allergy Notice, and Communicable Disease Summary

#### Handbook

Child Development Center Handbook is located at [www.worwic.edu](http://www.worwic.edu) under Child Development Center home page. Click the Parents Manual link to access the handbook. I have read and understand the contents of this handbook. I understand that I am aware of my responsibility for supplying all necessary information regarding my child and that I must continually update this information. I am also aware that I will be notified of any revisions of this handbook through my child's class mailbox. I am aware that the web address for Guide to Regulated Child Care Brochure is available in the CDC handbook and a copy may be given to me upon request.

\_\_\_\_\_  
Initials

#### Photo Release

I hereby consent to having my child(ren)'s photograph or myself used for publicity purposes by Wor-Wic Community College. I understand that the photographs may be used at any time for a variety of publicity purposes, including, but not limited to, classroom observations, news release to newspapers, television commercials and college publications such as the catalog, program brochures or website.

\_\_\_\_\_  
Initials

#### Allergy Notice

I have read and understand the letter regarding nut allergies in the Child Development Center. I understand that until further notice is given this will affect any lunches or snack I as a parent or guardian provide. If I have any questions about a product I am providing I will seek the help of the Center Staff.

\_\_\_\_\_  
Initials

#### Communicable Disease Summary

I have received a copy of the Communicable Disease Summary in the enrollment forms provided by the Child Development Center. I understand that this summary is presented by the state of Maryland.

\_\_\_\_\_  
Initials

I certify that I have read the above information and any reference material stated.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature of Parent/Guardian



**Child Care Centers  
Meal Benefit Application  
July 1, 2024 - June 30, 2025**

Complete one application per household. For more information, read **Instructions for Completing** or call **[410-334-2962]**

**Step 1** List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

**Step 2** Do any Household Members (including you) currently participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)? Circle One: Yes No

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number:

**Step 3** Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):  Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:     Check if No SSN:

**Step 4** Contact Information and Adult Signature

I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:	<input type="text"/>	Signature:	<input type="text"/>
Street Address:	<input type="text"/>		
Date:	<input type="text"/>	Phone #:	<input type="text"/>

**Step 5** OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

**Ethnicity (Check One):**

Hispanic or Latino  
 Not Hispanic or Latino

**Race (Check one or more):**

American Indian or Alaskan Native       Black or African American       White  
 Asian       Native Hawaiian or Other Pacific Islander

**DO NOT FILL OUT THIS SECTION. CENTER USE ONLY**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): \$   Weekly     Every 2 Weeks     Twice a Month     Monthly     Yearly

**Eligibility:**  Free     Categorically Eligible     Reduced     Paid

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Withdrawn: \_\_\_\_\_

**Maryland State Department of Education  
Office of School and Community Nutrition Programs  
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)  
ENROLLMENT FORM**

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, age, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home

1. Child's Name	Child's Date of Birth (MM/DD/YYYY)								
<p><b>Times Child Normally in Care</b> (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;"><b>Hours from:</b> _____ to _____</p>	<p><b>Check (✓) the days your child normally attends:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Monday</td> <td><input type="checkbox"/> Thursday</td> </tr> <tr> <td><input type="checkbox"/> Tuesday</td> <td><input type="checkbox"/> Friday</td> </tr> <tr> <td><input type="checkbox"/> Wednesday</td> <td><input type="checkbox"/> Saturday</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sunday</td> </tr> </table>	<input type="checkbox"/> Monday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Friday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Saturday		<input type="checkbox"/> Sunday
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<p><b>Check (✓) the meals that your child will receive while in care:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Breakfast</td> <td><input type="checkbox"/> AM Snack</td> </tr> <tr> <td><input type="checkbox"/> Lunch</td> <td><input type="checkbox"/> PM Snack</td> </tr> <tr> <td><input type="checkbox"/> Supper</td> <td><input type="checkbox"/> Evening Snack</td> </tr> </table>		<input type="checkbox"/> Breakfast	<input type="checkbox"/> AM Snack	<input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack	<input type="checkbox"/> Supper	<input type="checkbox"/> Evening Snack		
<input type="checkbox"/> Breakfast	<input type="checkbox"/> AM Snack								
<input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack								
<input type="checkbox"/> Supper	<input type="checkbox"/> Evening Snack								

2. Child's Name	Child's Date of Birth (MM/DD/YYYY)								
<p><b>Times Child Normally in Care</b> (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;"><b>Hours from:</b> _____ to _____</p>	<p><b>Check (✓) the days your child normally attends:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Monday</td> <td><input type="checkbox"/> Thursday</td> </tr> <tr> <td><input type="checkbox"/> Tuesday</td> <td><input type="checkbox"/> Friday</td> </tr> <tr> <td><input type="checkbox"/> Wednesday</td> <td><input type="checkbox"/> Saturday</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sunday</td> </tr> </table>	<input type="checkbox"/> Monday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Friday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Saturday		<input type="checkbox"/> Sunday
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3. Child's Name	Child's Date of Birth (MM/DD/YYYY)								
<p><b>Times Child Normally in Care</b> (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;"><b>Hours from:</b> _____ to _____</p>	<p><b>Check (✓) the days your child normally attends:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Monday</td> <td><input type="checkbox"/> Thursday</td> </tr> <tr> <td><input type="checkbox"/> Tuesday</td> <td><input type="checkbox"/> Friday</td> </tr> <tr> <td><input type="checkbox"/> Wednesday</td> <td><input type="checkbox"/> Saturday</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Sunday</td> </tr> </table>	<input type="checkbox"/> Monday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Friday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Saturday		<input type="checkbox"/> Sunday
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<input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack								
<input type="checkbox"/> Supper	<input type="checkbox"/> Evening Snack								

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone: \_\_\_\_\_



Dear Parents,

There are children in our center who have **life-threatening** allergies to peanuts. Children with peanut/nut allergies cannot eat, touch, or even inhale nut products. The reaction can be **deadly**.

We are asking for your help in reducing the risk of reaction by washing your children's hands and lips, and brushing their teeth after eating peanut butter or products with nuts before school.

Please do not send in foods that:

- Have peanuts/nuts in the ingredient list
- Has a warning that they may contain traces of peanuts/nuts
- Has a warning that they are manufactured on equipment or in a plant that processes peanuts/nuts

We realize that this is a lot to ask, and it may be an inconvenience for you. We are asking however, that you try to understand the danger. Something as simple as a cookie, a piece of candy, or touching a smear of peanut butter left behind, could be **deadly**.

Thank you very much for your cooperation.

Sincerely,

**Peanut  
Free Zone!**

Wor-Wic Child Development Center Staff

