WOR-WIC
COMMUNITY COLLEGE

Child Development Center

Enrollment Forms

JC Dolphins

2 Years Old

Creative Investigators

3-5 Years Old

License # 141284

WOR-WIC
COMMUNITY COLLEGE

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)

WOR-WIC COMMUNITY COLLEGE

CHILD DEVELOPMENT CENTER REGISTRATION FORM FOR CURRENTLY ENROLLED CHILDREN

Student ID Number _____ - _____ - _____ Year: _____

Parent Name: _____
Last First Middle

Child(ren)'s Name: _____
_____
_____
_____
Last First Middle

Telephone: _____ _____
Home or cell Work

- ☐ Fall
- ☐ Fall I
- ☐ Fall II
- ☐ Spring
- ☐ Spring I
- ☐ Spring II
- ☐ Summer
- ☐ Summer I
- ☐ Summer II
- ☐ Update/Change

Date: _____

COST PER WEEK: ☐ Student ($145 or $34 per day) ☐ Employee ($155) ☐ Community ($165)

Daytime Hours: Student minimum of three full days per week/ Employee and Community Full-time only

	Day	Number of Days	Time	# of Children	# of weeks (circle)	Days (x) Children
2 YEAR OLDS (MONDAY –FRIDAY)						
☐	Monday & Wednesday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	6 8 14 16	
☐	Tuesday & Thursday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	6 8 14 16	
☐	Friday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	6 8 14 16	
3 -5 YEAR OLDS (MONDAY – FRIDAY)						
☐	Monday & Wednesday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	6 8 14 16	
☐	Tuesday & Thursday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	6 8 14 16	
☐	Friday	2	7:30 – 5:00 p.m.	1 ☐ 2 ☐	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, parents will be charged for the two weeks. Please note that if the last two weeks tuition is not paid, 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: _____

WOR-WIC
COMMUNITY COLLEGE

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**

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

7:30 a.m. to 5:00 p.m.	☐ Monday/Wednesday	☐ Tuesday/Thursday	☐ Friday

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, optional part time status and discounted rate.

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.

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 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

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:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	**Name:**	**Name:**	☐ **Yes** ☐ **No**	**Physical Exam:**
Address:	**Address:**	**Address:**	**Child Care Scholarship**	**Dental Care:**
Phone:	**Phone:**	**Phone:**	☐ **Yes** ☐ **No**	**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	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ 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.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
Printed Name and Signature of Parent/Guardian Date

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

Child's Name: Last First Middle	**Birth Date:** Month / Day / Year	**Sex** M ☐ F ☐

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

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	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	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. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

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

Environmental Health Bureau
mdh.envhealth@maryland.gov

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 (µg/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 ≥3.5 µg/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 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)

Maryland State Department of Education
Office of Child Care

Medication Administration Authorization Form

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.

Place Child's Picture Here (optional)

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 #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

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

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

Maryland State Department of Education
Office of Child Care
MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				**Date of Birth:**	
Medication Name:				**Dosage:**	
Route:				**Time to Administer:**	
DATE ADMINISTERED	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

WOR-WIC
COMMUNITY COLLEGE

Child Development Center

Consent Form

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

Handbook

Child Development Center Handbook is located at www.worwic.edu under Child Development Center home page. Click the Parents Manual link to access the handbook or request a copy from the center associate. 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:		Signature:	
Street Address:			
Date:		Phone #:	

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
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

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)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____**to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

2. Child's Name		**Child's Date of Birth** (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____**to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

3. Child's Name		**Child's Date of Birth** (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____**to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____

WOR-WIC
COMMUNITY COLLEGE

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