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

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

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 or immunizations, 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 IMMUNIZATION CERTIFICATE

Maryland
DEPARTMENT OF HEALTH

STUDENT/SELF NAME: _____

LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	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 #	DOSE #1	DOSE #1	DOSE #6
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	DOSE #7
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	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #10
									DOSE #3		DOSE #3			

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

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 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

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

Diaper Consent Form

Our 2 Year Old Program is the only class we do diapering in. In order to provide your child with the utmost comfort, their diaper changing/toileting will be checked hourly. If your child shows any signs of redness etc., you will be notified when you pick your child up or via the communication folder. We will not use anything, such as cream, on your child unless you provide them and give instruction on its use.

I (parent/guardian)_____ give my permission for the staff of The Preschool at Riva Trace, located at 475 W. Central Ave. Davidsonville, MD 21035, to diaper change and/or assist (child's name)_____ with toileting when needed. I understand that my supplies (i.e. diapers, wipes, diaper cream etc.) will be used as directed on my child and that diaper changing/toileting will be done according to the child's needs. I also understand that my child's diaper will be changed quickly as possible if it becomes soiled. I agree to supply an extra change of clothes, wipes, diapers and any other supplies needed. I release The Preschool at Riva Trace from any and all responsibility concerning this matter.

Please put an X next to what applies to your child:

Potty Training _____

Potty Trained _____

Pull Ups _____

Diaper _____

Assistance with wiping needed _____

Parent's Signature _____Date_____

This consent expires 1 year after the date it was signed.

Revised 5/23

Permission to Apply Diaper Ointments or Creams

Child's Name _____

I, the parent/guardian of the above named child, give permission for the staff of The Preschool at Riva Trace within the 2 Year Old Class to apply the following topical diaper ointment/cream that I have provided for my child.

NOTE: Creams/lotions cannot be applied to broken skin without note from physician indicating specific permission. Physician must list name of cream or ointment to be used and for what duration (dates, amounts, etc.). The note from the physician, along with a completed Permission to Administer Non-Prescription Medication form must be obtained prior to any cream/ointment being used on a child with broken skin.

Name of diaper ointment or cream _____ (specific name of cream must be listed)

Apply the following amount of ointment or cream:

_____ thick coating

_____ thin coating

Apply at the following times:

_____ when skin in diaper area is red

_____ when rash is present in diaper area

_____ after each bowel movement

_____ with each diaper change

_____ Other: _____

Parent's Signature _____Date_____

This consent expires 1 year after the date it was signed.

Revised 5/23

Summer Program
Financial Agreement Form

Child's Name:_____ Child's Birthday:_____

Parent's Name:_____

Fee Information:
A 10% discount in tuition will be given to families with more than one child enrolled.

Payment is laid out as a daily amount of $48.00 per half day and $84.00 per full day. It is non-refundable. Payment is due in full by **June 17, 2026.**

Payment Information:
We accept checks and credit cards (Visa, MasterCard, Discover, or American Express) online via ProCare. Please do not send in payments with your child or give your payment to a staff member. Payments should be made out to The Preschool at Riva Trace or The P@RT. Mail your payments to: Riva Trace Baptist Church, 475 West Central Avenue, Davidsonville, Maryland 21035 Attn: Preschool Accounting Department or you may use the drop box in the Preschool office. Please be sure to write your child's name and class in the memo field of your check. At this time, we do not accept cash payments. Please feel free contact our financial assistant at boneal@rtbc.org to discuss any questions or concerns you may have.

A $25.00 fee will be charged for every returned check.

General Information:
Failure to make payments will result in the child's enrollment being cancelled.

We do not issue payment books. Tax Statements will be given upon request.

We do not make any tuition reductions due to extended absences of your child.

Unused funds may not be shifted to the regular school year.

Please be prompt at dismissal time as tardiness may cause anxiety in your child. Parents who do not pick up their children by dismissal time will incur an overtime charge as outlined in the parent handbook. If there is a consistent issue with tardiness at dismissal time you will be contacted by the Director or a Pastor, and childcare charges may be applied.

The Preschool and Kindergarten will observe State of Emergencies/Stay at Home orders as issued by the government. Prolonged closures may result in a change of tuition charged. Notification will come from the Director via email.

If there is a problem with non-payment, delinquent payments, or returned checks you will be contacted by the Director and a Pastor. We reserve the right to remove a child for non-payment of tuition and fees.

Signature: _____ **Date:**_____

OUR MISSION STATEMENT

The Preschool and Kindergarten at Riva Trace (The P@RT/K@RT) strives to create a quality Christian learning environment to equip children for their academic future and seeks to partner with parents who desire their child to grow in knowledge, faith, and love.

OUR PHILOSOPHY

The P@RT/K@RT believes in fostering child growth and learning in a developmentally appropriate environment through our faith-based program. The P@RT/K@RT Staff is dedicated to providing academic readiness in a Christ-centered, loving, and nurturing setting. Our goal is to assist each of our students in developing academically, physically, emotionally, socially, and spiritually. The P@RT/K@RT looks to achieve these goals through competent, caring, and qualified staff and through the daily lessons and activities set forth by our approved curriculum and pacing guides, MSDE learning standards and assessments, and our age-appropriate Bible-based lessons.

OUR PARTNERSHIP

The P@RT/K@RT is a ministry of and is overseen by Riva Trace Baptist Church. We realize that parents are a child's first and best teacher, and our program seeks to partner with those who agree with, support, and will further The P@RT/K@RT's mission and philosophy as well as the beliefs outlined by Riva Trace Baptist Church. Upon request, parents may obtain a copy of our church's Statement of Faith.

As a ministry of Riva Trace Baptist Church, The P@RT/K@RT will regularly invite and welcome families to participate in activities sponsored by the church (such as Sunday Worship and children's programming, MOPS and MomsNext, AWANA, and seasonal celebrations and community service opportunities). When parents choose to be a part of The P@RT/K@RT, they can be assured that their child will be surrounded by a positive program centered in sharing the love of Christ.

From monthly Bible verses to the arts and crafts, the weekly chapel message to the math and science activities, the circle times to the story times, The P@RT/K@RT wants children to know "God loves me, God made me, and He wants to be my friend forever!"

I have read and understand the above information in The P@RT/K@RT at Riva Trace's "Mission, Philosophy and Partnership" statement.

_____

Signature of Parent Date (mm/dd/yy)

475 W. Central Avenue, Davidsonville, MD 21035 - 410.798.4868, ext.123 - thekindergarten@rtbc.org

The Preschool at Riva Trace
The Kindergarten at Riva Trace
Discipline Policy

Discipline at The Preschool at Riva Trace and Kindergarten at Riva Trace is designed to encourage the development of self-control in the child. A child who is in control of his or her behavior is happier and better able to learn from the classroom experience. The staff of The P@RT and K@RT handles all discipline situations with patience, love, and understanding. Our goal is to nurture and care for the children while stressing Christian values in the positive growth of each child.

RULES OF BEHAVIOR

- Students will follow the rules of safety in the classroom and on the playground as instructed by the teachers.
- Students will follow general rules of polite behavior.
- Students will display no roughness of any kind. This includes pushing, kicking, pinching, grabbing, etc.
- Students will not use name calling or disrespectful language.
- Students will respect the property of others.

Appropriate behavior is praised and encouraged, however, occasionally a child may need to be reminded of what is expected of him or her in the classroom or on the playground.

Our discipline is as follows:

1st step	Positively redirect the child by reminding him or her of what is allowed in the classroom or on the playground. The child will be redirected to another activity to help him/her regain control of their behavior (in effect this is a warning).
2nd step	If the child has not regained control of his or her behavior, he/she may need a few minutes to calm down. (This is a consequence for their behavior).
3rd step	If the child continues to have difficulty with self-control the director will be notified.
4th step	If the director warrants it necessary, the parent will be notified and asked to pick up the child for that day.

The teacher will have ongoing communication with the parent of a child with difficult behavior.

If a child repeatedly has difficulty in the classroom or playground with self-control, the Director will take the issue to The P@RT and The K@RT Supervising Pastor and RTBC Elder Board. The Pastor and Elder Board will make a decision as to whether to ask the child to leave The P@RT or The K@RT.

Print student's name: _____

Print parent's name: _____

Parent's signature: _____ Date: _____

Revised 7/23

Departure and Contact Authorization

Please list the people who will be responsible for picking up your child/children at departure time. Please make sure at least one person is a non-family member. This is to help our staff make sure that your child is safe. Please let us know immediately if any of these people change or if additional people need to be added.

If anyone other than those on this list come to pick up your child, you must turn in written notice indicating your intentions, or they must have your carline tag.

Your Name:_____ Child's Name:_____

Class_____ Today's Date_____

1._____Relation to Child_____

Cell Phone #_____

2._____Relation to Child_____

Cell Phone #_____

3._____Relation to Child_____

Cell Phone #_____

4._____Relation to Child_____

Cell Phone #_____

Help us stay in contact with your family to alert you to the latest news, possible delays, and information concerning The Preschool and The Kindergarten.

Best Email Address:_____

Best Number to receive texts: _____

Additional email address to receive info:_____

_____

Additional phone numbers to receive texts:_____

_____

Signature_____ Date_____

Revised 6/2026