New Interest Information 2012/2013

First Evangelical Lutheran Church ~ Preschool

8397 Piney Orchard Parkway, Odenton, Md. 21113
(410) 672-3357 / www.felcodenton.org
Rev. Scott M. MacDonald, Pastor
Elizabeth Meyer, Preschool Director

Thank you for your interest in First Lutheran's Preschool Program. In order to attend our preschool, your child must be 3 or 4 years of age, depending on the class selected, by September first of the year attending, and bathroom independent. Please read the information below to get more information about our program. We encourage you to stop by and visit with us on any regular school day, but please call ahead to make sure we are not on a field trip or doing something outside the building.

First Lutheran's preschool program has been around for nearly 60 years (est. 1950). It is a great testament to our program that a lot of previous attendees are now bringing their children and even grandchildren back to us. At First Lutheran, we teach colors, letters, shapes, religion, how to play and get along with others and kindness. Our religious activities do not teach Lutheran doctrine. We teach good Christian values. The pastor meets with the children for a special worship time each week.

MONTHLY EMPHASIS

Each month we will have a special Emphasis on topics such as Transportation, Farming, Safety or Manners. Field trips focusing on this emphasis will be taken every month except January when it is frigid outside and we have some very important guests visit with us here at the school.

A typical day will include:

- *Play Time*
- *Circle Time (we will learn new songs and poems or work on numbers, letters, shapes & colors)*
- *Table time (focusing on monthly emphasis we will do worksheets or crafts)*
- *Religion*
- *Snack*
- *Story time*

DISCIPLINE

We must maintain order in preschool and now is the critical time to learn these rules and regulations. We know it may be a difficult time for some of our precious angels but have set up a great way to deal with some issues we may have.

- *First offense: Talk to the child about our preschool rules and kindness*
- *Second offense: Remove the child from the situation.*
- *Third offense: The child's name will be put on the chalk board under our sad face and 5 minutes of a privilege will be taken away.*
- *Fourth offense: We will talk to the parents if it is a continuing problem.*

TUITION

We have two classes available. The four (4) year old class is Monday through Friday, 9:00 AM to 11:30 AM, and $200.00 per month. Our Three (3) year old class is Tuesday through Thursday, 1:00 PM to 3:00 PM, and is $150.00 per month. Tuition is due by the 5th of each month. For example, the September Tuition is due no later than September 5th.

FORMS

Within this packet you will find the following forms. These forms have specific times that they must be received into our office. If you need to make special arrangements, please contact us. There is a $50.00 non-refundable registration fee due when you register in order to hold the opening. Your child in not considered part of our program until the registration fee and form is received in our office. We reserve each spot on a first come first serve basis.

Form	***When Due***	***Date Turned in***
Registration Form	*Holds spot for child plus $50.00 fee*	
Emergency Form	*Before the First Day of School*	
Health Inventory	*Before the First Day of School*	
Health Inventory Addendum	*Before the First Day of School*	
All About my Child	*Before the First Day of School*	
All About my Child Instructions	*Yours to Keep*	
Medication Emergency Plan	*Only if needed on the First Day of School*	

Thank you so much for your interest. We would love to have your precious child join us this coming year but, no matter where your child attends we pray that your preschool experience is a wonderful one. The next couple of years are influential years for them. A lot of learning and growing will happen in the next year. What a wonderful experience for all who are involved.

God Bless,
First Lutheran Preschool Staff

Contact Information:

Office Phone: 410-672-3357
Email: churchoffice@felcodenton.org
Check out the website: www.felcodenton.org
Address: 8397 Piney Orchard Parkway, Odenton, Md. 21113

Registration Form for 2012/2013

First Evangelical Lutheran Church ~ Preschool

8397 Piney Orchard Parkway, Odenton, Md. 21113

(410) 672-3357 / www.felcodenton.org

Rev. Scott M. MacDonald, Pastor

Elizabeth Meyer, Preschool Director

Child's Full Name ____
(Last) (First) (Middle)

Name child goes by ______________________ Place of birth ______________________________

Date of Birth ____ Sex __________________________

Childs Home Address: ____
(Street) (Apt. #) (City) (Zip)

Child's Home Phone ____________________________ Email Address: __________________________________
(Area Code)

PARENT OR GUARDIAN INFORMATION

Father's Name ____________________________________ Phone __________________________

Father's Address ____

Father's place of employment ____

Work Phone ______________________________ Mobile Phone ____________________________

Mother's Name ____________________________________ Phone __________________________

Mother's Address ____

Mother's place of employment ____

Work Phone ______________________________ Mobile Phone ____________________________

FAIMLY INFORMATION

Brother & Sisters	Name	Birth Date
	__________________________	________________________
	__________________________	________________________
	__________________________	________________________

Please list any other person living with the child and their relationship to the child

____

Church in which you are an active member (if any) ____________________________________

Child attends Sunday School at ____

Child's Doctor __________________________________ Phone ____________________________

Address ____

$50.00 non-refundable registration fee: Make all checks payable to First Evangelical Lutheran Church Memo Line: Preschool

Class Child will attend: 4-year-olds ____ (Mon.-Fri. 9:00 am – 11:30 am) $200.00 per month
3-year-olds ____ (Tues.-Thurs. 1:00 pm – 3:00 pm) $150.00 per month

PICK UP:

Persons authorized to pick up child ____

____

Persons **NOT** authorized to pick up child (If applicable) ____

____

PERSONAL HISTORY:

Language spoken in home other than English ____

Is your child right handed or left handed? ____

Has your child had a previous group or preschool experience? ____

If yes, when and where? ____

Does your child have allergies? ____

Are there any medical problems of which we should be aware? ____

____

What word does your child use for the bathroom needs: ____

Are there any special food or eating instructions? ____

Special attachments? (i.e. blanket) ____

Likes ____

Dislikes ____

Particular fears ____

How is your child's anger expressed? ____

How do you discipline your child? ____

Does your child have any particular habits? ____

What is your child's concept God? ____

Child's strengths, in your opinion? ____

Any additional information about your child ____

____

____ ________________________________

(Parent/Guardian Signature) (Date)

OFFICE USE: Registration & Fee received ____

Medical Alert: ____________________ (Yes) ____________________ (No) ____________________

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(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.

When parents 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 ______________

Child's Name ______________________________ Birth Date ______________
Last First

Enrollment Date ______________ Hours & Days of Expected Attendance ______________

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

Mother's Name ______________________________ Home Telephone ______________
Last First

Mother's Employer/School ____
Name Address

Mother's Home Address (*If different from above*) ______________________________
Street/Apt.# City State Zip Code

Work Telephone ______________ Cellular Phone ______________ Beeper ______________

Father's Name ______________________________ Home Telephone ______________
Last First

Father's Employer/School ____
Name Address

Father's Home Address *(If different from above)* ______________________________
Street/Apt.# City State Zip Code

Work Telephone ______________ Cellular Phone ______________ Beeper ______________

Name of Person Authorized to Pick Up Child *(daily)* ______________________________
Last First Relationship to Child

Address ____
Street/Apt.# City State Zip Code

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

INSTRUCTIONS TO PARENT:

(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

Vaccine Requirements For Children Enrolled in Preschool Programs and in Schools

Per DHMH COMAR **10.06.04.03**

Maryland School Year 2010 - 2011 (Valid 9/1/10 - 8/31/11)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs

Vaccine / Current Age of Child	DTaP/DTP/ DT	Polio[2]	Hib[3]	Measles[2,4]	Mumps[2,4]	Rubella[2,4]	Varicella[2,4,5] (Chickenpox)	Hepatitis B	PCV[3] (Prevnar™)
Less than 2 months	0	0	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	0	0	1	1
4 - 5 months	2	2	2	0	0	0	0	2	2
6 - 11 months	3	3	2	0	0	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	1
60 - 71 months	4	3	0	2	2	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12th grade

Grade Level: Grade	(Ungraded)	DTaP/DTP/ Tdap/DT/Td[1]	Polio[2,7]	Measles[2,4]	Mumps[2,4]	Rubella[2,4]	Varicella[2,4] (Chickenpox)	Hepatitis B[8]
Kindergarten	(5 yrs)	4	3	2	1	1	1	3
Grades 1 - 12	(6 - 18+ yrs)	4 or 3[6]	3	2	1	1	1 or 2[5]	3

* See footnotes on back

Maryland Department of Health & Mental Hygiene
Center for Immunization

www.EDCP.org (Immunization)
410-767-6679

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools
Maryland School Year 2010 - 2011 (Valid 9/1/10 - 8/31/11)

FOOTNOTES

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.

2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella.

3. Hib and PCV(Prevnar™) are not required for children older than 59 months (5 years) of age.

4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before first birthday.

5. One dose of varicella (chickenpox) is required for a student younger than 13 years old. Two doses of varicella vaccine are required for a previously unvaccinated student 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a physician or health care provider. Documentation must include month and year. In the absence of documentation a medical provider or local health department may verify immunity via blood test, **but revaccination may be more expedient.**

6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccines (DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older.

7. Polio vaccine is not required for persons 18 years of age and older.

8. Two doses of Hepatitis B vaccine is acceptable only if the student was vaccinated with the Merck & Co. brand vaccine **Recombivax™ HB Adult Formulation**. Recombivax™ HB Adult Formulation vaccine is licensed for use in adolescents 11 - 15 years of age as a two-dose series.

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name ______________________________ ______________
Last **First** **Middle** **Birth Date**

Name of Parent or Guardian ______________________________ ______________
Relationship

Home Address ______________________________

City ______________ **State** ________ **Zip Code** ____________

Check Best Telephone Number to Reach You:

☐ **Home #:** ____________ ☐ **Work #:** ____________ ☐ **Cell #:** ____________

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: ______________________________

Address: ______________________________

____
City/Town **State** **Zip Code**

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN** **CHILD'S NAME: ________________________**

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	_____	_____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	_____	_____
Date of last eye examination: _____/ _____/ _____ Doctor's Name: ___________________________		
Results: ____		
Does your child wear glasses?	_____	_____
Contact lenses?	_____	_____
3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*?	_____	_____
Date of last hearing evaluation _____/ _____/ _____ Doctor's Name: ___________________________		
Results: ____		
Does your child use a hearing aid?	_____	_____
4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.*)?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c:	_____	_____
(a) Does this condition require any special health care in the child care facility?	_____	_____
(b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs?	_____	_____
(c) Does your child require any special adaptations or adaptive equipment?	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

REMARKS (*Provide further explanation for all "YES" answers):* ____

____

____

____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

___________________________________ _________________

Signature of Parent/Guardian **Date**

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER** **CHILD'S NAME:** ______________________

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ____ Positive ____ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)
   - a. Vision problem ☐YES ☐ NO ______________________
   - b. Hearing problem ☐YES ☐ NO ______________________
   - c. Speech or language problem ☐YES ☐ NO ______________________
   - d. Other physical illness or impairment ☐YES ☐ NO ______________________
   - e. Mental, emotional or behavior problems ☐YES ☐ NO ______________________
   - f. Developmental delays ☐YES ☐ NO ______________________
   - g. Allergies ☐YES ☐ NO ______________________

   Significant physical findings, comments and recommendations: ______________________

4. This child has a health condition which may require care or emergency action while at child care. ☐YES ☐ NO

   If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): ______________________

   ____

   Recommendations: ______________________

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

   ☐YES ☐ NO If YES, please specify: ______________________

6. This child requires a modified diet and/or special feeding procedures. ☐YES ☐ NO

   If YES, please specify: ______________________

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

   ____

8. Does this child's physical activity need to be restricted? ☐YES ☐ NO

   If YES, please specify: ______________________

9. Does this child require any specialized treatment? ☐YES ☐ NO

   If YES, please specify: ______________________

10. Does this child require any adaptive equipment (braces, crutches, etc.)? ☐YES ☐ NO

    If YES, please specify type: ______________________

    Special instructions for use: ______________________

RECORD OF IMMUNIZATIONS

Vaccine Types Enter: Month/Day/Year for each immunization administered												
Dose #	**DTP-DTAP**	**Polio**	**HIB**	**Hep B**	**PCV7**	**MMR**	**Varicella**	**Rotavirus**	**MCV4**	**HPV**	**Hep A**	**Other**
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name ____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a ☐ permanent ☐ temporary condition until ____/____/____. Check appropriate box, indicate vaccine(s) and reasons: ____

____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care.
(circle correct response)

______________________________________ ______________ ______________________________________
Signature of Health Practitioner **Date** **Phone Number**

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS	**Baltimore (cont)**	**Carroll**	**Frederick(cont)**	**Montgomery**	**Prince**	**St. Mary's**
BY	21210	21155	21783	20783	**George's(cont)**	20606
ZIP CODE	21212	21757	21787	20787	20782	20626
	21215	21776	21791	20812	20783	20628
Allegany	21219	21787	21798	20815	20784	20674
ALL	21220	21791		20816	20785	20687
	21221		**Garrett**	20818	20787	
Anne Arundel	21222	**Cecil**	ALL	20838	20788	**Talbot**
20711	21224	21913		20842	20790	21612
20714	21227		**Harford**	20868	20791	21654
20764	21228	**Charles**	21001	20877	20792	21657
20779	21229	20640	21010	20901	20799	21665
21060	21234	20658	21034	20910	20912	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237		21078	20913		21676
21226	21239	**Dorchester**	21082		**Queen Anne's**	
21402	21244	ALL	21085	**Prince George's**	21607	**Washington**
Baltimore	21250		21130	20703	21617	ALL
21027	21251	**Frederick**	21111	20710	21620	
21052	21282	20842	21160	20712	21623	**Wicomico**
21071	21286	21701	21161	20722	21628	ALL
21082		21703		20731	21640	
21085	**Baltimore City**	21704	**Howard**	20737	21644	**Worcester**
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	**Calvert**	21719	**Kent**	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204		21758	21645	20746		
21206	**Caroline**	21762	21650	20748	**Somerset**	
21207	ALL	21769	21651	20752	ALL	
21208		21776	21661	20770		
21209		21778	21667	20781		
		21780				

Medical Emergency Plan

The health care provider completes this form if child has a medical condition that may require emergency care as required by Comar 07.04.02.35

Child's Name: ______________________ Date of Birth: ______________

Medical Problem(s): ______________________

Allergies/Reactions: ______________________

____

Emergency Instructions:

A) Signs/Symptoms to look for: ______________________

____

B) When signs/Symptoms appear do this: ______________________

____

To prevent incidents: ______________________

____

Other specialized medical/hygiene procedures that may be needed:

____

____

____

Comments: ______________________

____

____

______________________ Physician Signature

______________________ Physicians Phone Number

______________________ Physicians Name

______________________ Signature of Parent/Guardian

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICATION AUTHORIZATION FORM

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions with prior written permission (Section A) from the child's parent/guardian. A separate form is needed for each prescription or non-prescription medication to be administered to the child.

PRESCRIPTION MEDICATIONS AND NON-PRESCRIPTION MEDICATIONS: **Prescription** medications must be in a container labeled by the pharmacy or physician with the child's name, dosage, and expiration date. At least one dose of prescription medication must be given at home prior to the child's arrival at the child care facility. **Non-prescription** medications must be in the original manufacturer's container labeled with instructions for dosage and expiration date. Except for acetaminophen (Tylenol) and other topical medications, a provider may administer only one dose of non-prescription medication to a child per illness unless a licensed health practitioner provides written approval (Section B) for the administration of the non-prescription medication and the dosage. All medication shall be administered according to the instructions on the label of the medication container or a licensed health practitioner's written instructions, whichever are more recently dated. **An adult should bring the medication to the center/provider.**

Name of Child: ______________________________________ **Date of Birth**: ______________ **Age**: ___________

SECTION A: (To be completed by parent/guardian for any medication to be administered to the child.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
I/We request that designated child care providers/or staff administer medication as noted on this form. I/We certify that I/We have legal authority to consent to medical treatment for the child named above, including administration of medication while in child care. I/We understand that at the end of the year or if the medication is discontinued or expired, an adult must pick up the medication, otherwise it will be discarded. **Signature of Parent/Guardian:** ____ **Date:** ___________________				

SECTION B: (To be completed by the Health Practitioner for approval to administer non-prescription medication more than one dose per illness, other than acetaminophen (Tylenol) or other topical medication.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
ADDITIONAL INSTRUCTIONS:				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
Health Practitioner's Signature:			**Date:**	
Print, Type or Stamp: Name, Address, Phone number and Title of Health Practitioner:				

MEDICATION ADMINISTERED

Except for the application of a non-prescription diaper rash treatment, sunscreen, or insect repellent supplied by the child's parent, each administration of a medication to the child shall be noted in the child's record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name: | **Date of Birth:**

Medication:

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

ALL ABOUT MY CHILD

INSTRUCTIONS

This tool was developed to help your child care provider support the growth and development of your child while creating a safe stable and healthy environment for all children.

STEP I: INFORMATION TO BE COMPLETED BY THE PARENT/GUARDIAN

IDENTIFYING INFORMATION: Fill in identifying information including your child's nickname.

THINGS MY CHILD DOES WELL: Indicate characteristics of your child's behavior and skills which you consider to be things your child does well in the following areas: physical activity, language, self-care, emotional, and social. Examples could include your child's problem solving ability, inquisitiveness, expression of thoughts, sharing ability, climbing skills, ability to use a spoon, fork, or drinking cup. Your child care provider can use these examples to help your child develop new skills.

WHAT MY CHILD LIKES AND DISLIKES: Indicate your child's likes and dislikes including toys, objects, people, foods, and activities. Indicate if fear is associated with any dislikes and discuss with your provider. Making a note of your child's likes and dislikes will help the provider make your child feel more comfortable.

THINGS I AM WORKING ON WITH MY CHILD: Let the child care provider know the skills and activities that you consider important for your child to learn and ones that you are working on at home, through school, or with a private practitioner. These could include self-help skills, language skills, social skills, coordination, large muscle activities, and/or behavior skills. The provider may be able to reinforce these efforts and provide consistency when appropriate.

MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES: Describe those activities in which your child most enjoys participating, such as circle games, climbing, running, or bike riding. This knowledge will help the child care provider plan activities to include your child.

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES: Indicate if your child dislikes, has difficulty with, or is physically restricted from performing certain activities. Examples of this may include a dislike of playing games with balls, falling frequently when climbing, or a restriction from participating in strenuous exercise.

MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES: Indicate if your child needs equipment to participate fully in the program. Equipment may include such things as glasses, a wheelchair, braces, crutches or other walking aids, a hearing aid, a helmet, a communication board, a nebulizer, special feeding utensils, and/or other adaptive devices. If applicable, include directions and demonstrate how the equipment is to be used. Indicate if the child requires any procedures or treatments. These may include blood glucose monitoring, catheterization, positioning, special exercises, a plan for emergency care, and/or a behavior management program. Directions may be provided by the parents, physician, or other professionals.

ALL ABOUT MY CHILD

INSTRUCTIONS (continued)

THINGS MY CHILD MIGHT NEED HELP WITH: Indicate if the child requires individual attention. This may be required only during certain activities or during the entire time the child is in care. Some examples are help with tying shoes, help with cutting food, or encouragement to participate in group activities or to sit still, reinforcement of a behavior management program, or intermittent catheterization. Any need for additional supervision is determined between the parent/guardian and the provider.

STEP II: THE PROVIDER'S PART

WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? *(For the use of the provider when necessary)*: In addition to the established provisions of the program, indicate any modification of the program necessary to meet the unique needs of this child. Examples may include adding activities that this child especially likes or performs well, providing extra supervision when the child is performing difficult activities, removing anything to which the child is allergic, rescheduling activities so that they do not interfere with any treatments, moving furniture to accommodate wheelchairs, and adapting activities so that the child will be included. Decisions may be made in cooperation with the parent/guardian.

STEP III: USE OF THE INFORMATION GATHERED

ONGOING: The provider should be familiar with the information gathered on this form before working with the child. ***All information collected shall be confidential. Written parental permission must be obtained prior to sharing this information with anyone other than the provider(s) and the Child Care Administration's Licensing Specialist. The information needs to be updated as the child's need(s) change or at a minimum, annually.*** Revision of program plans can occur at any time based on observations of the child or updated evaluations (it may be helpful to make updates in a different color ink). It is important that the parent/guardian and provider devote time to discuss the child's day-to-day behavior and participation in activities. By doing this routinely, problems can be prevented.

DAILY: The provider/staff must have daily access to each child's personal information in order to adequately provide for the safety and care of each child. The information may be used to schedule procedures, treatments, program modifications, and/or additional supervision. The provider plans the program of activities to enable each child to participate with the group as much as possible.

ANNUALLY: This information must be reviewed and updated ***at least once a year*** by the parent/guardian. The parent/guardian and provider must initial and date the form when it is reviewed each year.

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

ALL ABOUT: ______________________________
Child's First Name or Nickname

Child's Name: ______________________________ Birthdate: ______________

Parent/Guardian: ______________________ Home Phone: ______________ Work Phone: ______________

Address: ______________________________ Zip Code: ______________

Provider/Center: ______________________________ Phone: ______________

Address: ______________________________ Zip Code: ______________

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES
MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES
THINGS MY CHILD MIGHT NEED HELP WITH
WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: ______________________ Date: __________

Provider: ______________________ Date: __________

Updates:

Parent/Guardian: __________ Date: ______ Parent/Guardian: __________ Date: ______

Provider: ______________ Provider: ______________