

# Community Christian Preschool (CCPS) Registration 2020-2021

Name of Child \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
 Likes to be called \_\_\_\_\_ Gender: Male  Female  Date of Birth \_\_\_\_\_

Please use the chart below to select your child's age as of September 1, 2020. Then please pick the class days/time for your child in the chart. Mark it on chart below and be sure to sign on the line to the right of your child's schedule.

<b>②</b> 9:00 AM – 12:15 PM Monday / Wednesday / Friday <b>\$290</b> Tuesday / Thursday <b>\$215</b>	<b>③</b> 9:00 AM – 1:30 PM Monday / Wednesday / Friday <b>\$395</b> Tuesday / Thursday <b>\$245</b>	<b>④</b> 9:00 AM – 3:00 PM Monday – Friday <b>\$570 1<sup>st</sup> priority</b> Mon / Wed / Fri <b>\$415 2<sup>nd</sup> priority</b>
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Classes	②	③	④
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Check the blocks needed to create your Child's Preschool Schedule

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

Director's Initials: \_\_\_\_\_

Public Pre-K applicant: \_\_\_\_\_

Yes

No

**NOTE: If you have applied for your child to enter the public Pre-K system, we will put your child's application on our wait list.**

## Preschool After Care Registration

After Care is offered as an additional service once preschool has ended. If interested in signing your child up please select the appropriate age and the days you would like for your child to stay. After care times run from 12:15pm to 3:00 pm for the 2's and 1:30pm-3:00 pm for the 3's.

	<b>②</b> 12:15 PM – 3:00 PM (*INCLUDES PARENT-PROVIDED LUNCH) <b>\$35/day</b>	<b>③</b> 1:30 PM – 3:00 PM <b>\$25/day</b>
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

### FOR OFFICE USE ONLY:

Check

Cash

EFT on File

New EFT

Credit Card

Credit Card#: \_\_\_\_\_

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

CVV: \_\_\_\_\_

# COMMUNITY CHRISTIAN PRESCHOOL (CCPS) ENROLLMENT AGREEMENT School Year 2020-2021

Phone (410) 255-9250 Email: admin@ccpspasadena.org

**Initial each row to confirm your acceptance of the Enrollment Agreement:**

I understand that a \$100.00 Registration Fee is charged upon submission of this Registration Form/Enrollment Agreement and completed paperwork. Once received by the Director and acknowledged then enrollment is secured.	
I understand the Registration Fee is non-refundable.	
Tuition payments are due on the first and fifteenth of each month beginning September and continuing through May. Tuition can be paid in full in advance or monthly. A 5% discount is applied for families with 2 or children enrolled. If tuition is not received by the fifteenth of the month, it is considered delinquent, and a late notice and a fee of \$25 will be applied to the tuition payment. A \$25 returned check fee will be charged for all returned checks and a \$10 fee will be charged for returned EFTs.	
I understand that my child must be two years old by September 1 for all two-year-old programs, three years old by September 1 for all three-year-old programs and four years old by September 1 for all four-year-old programs. There are no exceptions or changes to this policy.	
I understand that enrollment is for the entire school year, September through May, and that I agree to make regular payments for the entire term with any exceptions to this to be considered by the Board.	
I understand that the Community Christian Preschool honors the same calendar schedule as Anne Arundel County School System in regard to holidays, professional days, emergency closings, and other days off from school as close as possible with a few exceptions.	
I understand for birthday celebrations that my child's birthday will be celebrated with birthday crowns, stickers and recognition. No food or treat bags will be permitted.	
Community Christian Preschool may take and/or use my child's photograph or digitized image for educational and information purposes in the classroom and/or building only. No children's names or photos will be published on any web or social media site.	
My child, _____, has permission to attend Community Christian Preschool and participate in all class and playground activities with the understanding that the group will be supervised by a teacher, assistant teacher or other designated adult. My permission is hereby given to the staff members of the CCPS to take my child to the doctor herein designated or to the nearest hospital and authorize treatment for the child herein named in the event of accidental injury if I cannot be reached.	
Does your Child have an IEP or an ISFP? <span style="float: right;">Yes <input type="checkbox"/></span> <span style="float: right;">No <input type="checkbox"/></span>	
If yes, would you please share with us? <span style="float: right;">Yes <input type="checkbox"/></span> <span style="float: right;">No <input type="checkbox"/></span>	
Special needs of the child (ECI, Speech, Occupational Therapy): _____	

Signature of Parent

Date

## 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.

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	Phone Number(s)		
		Place of Employment:	C:	H:
		_____		
		W:		
		Place of Employment:	C:	H:
		_____		
		W:		

Name of Person Authorized to Pick up Child (*daily*) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES** \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

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

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

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

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

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

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

**Note to Health Practitioner:**

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

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

\_\_\_\_\_  
Date

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

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

**COMMUNITY CHRISTIAN PRESCHOOL (CCPS)**  
**CHILD CUSTODY INFORMATION School Year 2020-2021**

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Child's name \_\_\_\_\_

Date \_\_\_\_\_

If your child lives with both parents and there are **no** custody issues, please complete this form and indicate this checking this statement and signing below.

\_\_\_\_\_ There are **no** custody issues regarding my child.

If your child **DOES NOT** live with both parents, please provide a copy of the custody agreement.

If you **DO NOT** supply a copy of a custody agreement, your child can be picked up by either parent at any time. Please initial here and sign below indicating your acceptance of this information.

Initials: \_\_\_\_\_

\_\_\_\_\_  
Parent's signature

## COMMUNITY CHRISTIAN PRESCHOOL (CCPS) FOOD PERMISSION School Year 2020-2021

Community Christian Preschool is a peanut and tree nut free school. CCPS serves a daily snack to students each day, along with water to drink. Examples of our snacks include fresh fruit, goldfish crackers, yogurt, graham crackers, cheese sticks, and sliced cheese and crackers. We celebrate Thanksgiving as a community with Chik-fil-A chicken nuggets, cheese, fruit, and a dessert.

Please inform immediately CCPS if your child has any food allergies or food sensitivities such as gluten, lactose, etc. Any known food allergies and medication must be documented with an Allergy Action Plan form and signed by a physician. Please contact the office if you have any questions.

Please sign the permission below for your child to eat at CCPS.

I, \_\_\_\_\_, give/decline permission for my child \_\_\_\_\_ to eat daily snack and the Thanksgiving feast.

Please provide the following information:

\_\_\_\_ My child DOES NOT have a food allergy or dietary restriction. He or she may participate in activities.

\_\_\_\_ My child DOES have a food allergy or dietary restriction. He or she may participate in activities, but may not eat or handle the following items (please list below):

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\_\_\_\_ My child DOES have a food allergy or dietary restrictions. He or she may not participate in activities.

I understand that it is my responsibility to update this form in the event that my decision for permission changes. I agree that this form will remain in effect during the entire school year.

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Parent's signature and date



# All About Me

\_\_\_\_\_  
(Child's Full Name)

ATTACH PICTURE OF CHILD

Name your child would prefer to be called.

What formal school experience has your child had? Where?

Does your child have difficulty separating from parents? (Please explain)

Please let us know of any special needs that your child might have. (allergies, sensitivities, speech delays, suspected learning delays or behavior problems)

What activities does your child enjoy?

What activities does your child dislike?

Does your child have any fears? (Please explain)

Is your child potty trained or in the process of being potty trained?  
(2's only. All other children are required to be potty trained)

How is your child best motivated?

Who lives at your home? Please list names, relation to child and ages of siblings. (parents, grandparents, siblings, pets, etc.)

Please let us know about religious practices and parenting practices that you feel would help us better serve your family.

Do you have a special talent or profession that you would like to share with the class?



# HEALTH INVENTORY

## Information and Instructions for Parents/Guardians

### **REQUIRED INFORMATION**

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

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:

[http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland\\_immunization\\_certification\\_form\\_dhmh\\_896\\_-\\_february\\_2014.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf)

- **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: [http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh\\_4620\\_bloodleadtestingcertificate\\_2016.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf)

### **EXEMPTIONS**

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

### **INSTRUCTIONS**

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

<http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.



**PART I - HEALTH ASSESSMENT**

**To be completed by parent or guardian**

<b>Child's Name:</b>			<b>Birth date:</b>			<b>Sex</b>	
_____ Last                                      First                                      Middle			_____ Mo / Day / Yr			M <input type="checkbox"/> F <input type="checkbox"/>	
<b>Address:</b>							
_____ Number      Street		_____ Apt#      City		_____ State      Zip			
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>		<b>Phone Number(s)</b>			
				W: _____		C: _____	
				W: _____		C: _____	
<b>Your Child's Routine Medical Care Provider</b>				<b>Your Child's Routine Dental Care Provider</b>		<b>Last Time Child Seen for Physical Exam:</b>	
Name: _____				Name: _____		Dental Care: _____	
Address: _____				Address: _____		Any Specialist: _____	
Phone # _____				Phone _____			
<b>ASSESSMENT OF CHILD'S HEALTH</b> - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.							
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>				
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>					
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>					
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>					
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>					
Bladder	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>					
Bowels	<input type="checkbox"/>	<input type="checkbox"/>					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>					
Coughing	<input type="checkbox"/>	<input type="checkbox"/>					
Communication	<input type="checkbox"/>	<input type="checkbox"/>					
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Feeding	<input type="checkbox"/>	<input type="checkbox"/>					
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>					
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>					
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>					
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>					
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>					
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>					
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>					
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
<b>Does your child require any special procedures?</b> (Urinary Catheterization, G-Tube feeding, Transfer, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____							
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.  <b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>							
Signature of Parent/Guardian _____						Date _____	

**PART II - CHILD HEALTH ASSESSMENT**  
**To be completed ONLY by Physician/Nurse Practitioner**

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

1. Does the child named above have a diagnosed medical condition?  
 No     Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.  
 No     Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/ or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: [http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland\\_immunization\\_certification\\_form\\_dhmm\\_896\\_-\\_february\\_2014.pdf](http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmm_896_-_february_2014.pdf))

**RELIGIOUS OBJECTION:**  
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

5. Is the child on medication?  
 No     Yes, indicate medication and diagnosis:  
**(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).**

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

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1                      Test#2	Test # 1                      Test #2

\_\_\_\_\_ **has had a complete physical examination and any concerns have been noted above.**  
(Child's Name)

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

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE**

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

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

CHILD'S NAME \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 LAST FIRST MIDDLE  
 CHILD'S ADDRESS \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 STREET ADDRESS (with Apartment Number) CITY STATE ZIP  
 SEX:  Male  Female BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PHONE \_\_\_\_\_  
 PARENT OR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 GUARDIAN LAST FIRST MIDDLE

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

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

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

Parent or Guardian Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

Comments:

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

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Office Address: \_\_\_\_\_

**BOX D – Bona Fide Religious Beliefs**

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

Parent or Guardian Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

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

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Office Address: \_\_\_\_\_

## HOW TO USE THIS FORM

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

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

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

### Lead Risk Assessment Questionnaire Screening Questions:

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

## How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.**

### Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient.**
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

**MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE**

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

**RECORD OF IMMUNIZATIONS (See Notes On Other Side)**

Vaccines Type													
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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name  
Office Address/ Phone Number

1. \_\_\_\_\_  
 Signature Title Date  
 (Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

**Please check the appropriate box to describe the medical contraindication.**

This is a:  Permanent condition OR  Temporary condition until \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
 Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

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