MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

DAILY 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.

(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: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

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: _____

_____

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

TLC Child Profile for Twos

PLEASE PRINT CLEARLY

Child's Name _____ **Date** _____ **Age** ____ **Birthday** _____

You know your child better than any one else in the world! You have observed your child's growth on a day-to-day basis, and you are uniquely qualified to share that with us. Please take time to complete this profile for your child. This information will help us know your child better and meet his/her individual needs.

1. What would you like most for your child to experience with us?

_____

2. Do you have any concerns about your child's development? If yes, please explain briefly.

_____

_____

3. Have you discussed your concerns with your pediatrician? Yes No

4. What language or languages are spoken in the home? _____

5. Does your child use words to communicate? Yes, most of the time Sometimes No words used yet

6. Does your drink from a cup? Yes No (**TLC does *not allow baby bottles or sippy cups***)

7. Does your child use a spoon and a fork for eating? Yes No

8. Is your child toilet trained as evidenced by wearing underwear? Yes No

9. Does your child wear pull-ups? Yes No

10. Does your child know how to pull-up and push down their pull-ups? Yes No

11. What words/phrases are used for toileting? _____

12. Does your child take naps? ___ How long does your child nap? ___

13. Does your child wear a pull-up for naps? _____

14. Does your child need a favorite item (blanket, stuffed animal, etc.) for a nap? Yes____ No____

15. Has your child been assessed by a professional for any ***developmental delays***? Yes No

Speech and language? Yes No

Cognitive delays?_____ Other? _____

16. Does your child have an ***Individual Family Service Plan (IFSP) or an IEP***? ____ Does your child receive any special services through a county early childhood special center? If yes, please give the name of the center or facility. _____

17. Would you be willing to share testing results/reports and/or IEP information with our Educational Director?

Yes No

New students are admitted under a **two week probationary period** during which time TLC staff will evaluate whether the TLC program is developmentally appropriate for your child. We believe it is important for each child to have a positive preschool experience.

Parent's Signature _____ **Date** _____

TLC Child Profile for Threes

PLEASE PRINT CLEARLY
Child's Name _____ **Date** _____ **Age** ____ **Birthday** _____

You know your child better than any one else in the world! You have observed your child's growth on a day-to-day basis, and you are uniquely qualified to share that with us. Please take time to complete this profile for your child. This information will help us know your child better and meet his/her individual needs.

1. What would you like most for your child to experience with us?

_____

2. Do you have any concerns about your child's development? If yes, please explain briefly.

_____

_____

3. Have you discussed your concerns with your pediatrician? Yes No

4. What language or languages are spoken in the home? _____

5. Does your child use words to communicate? Yes, most of the time Sometimes No words used yet

6. Is your child toilet trained as evidenced by wearing underwear? Yes No

7. Does your child wear pull-ups? Yes No

8. Does your child know how to pull-up and push down their pull-ups? Yes No

9. What words/phrases are used for toileting? _____

10. Does your child take naps? ___ How long does your child nap? ___

11. Does your child wear a pull-up for naps? _____

12. Does your child need a favorite item (blanket, stuffed animal, etc.) for a nap? Yes____ No____

13. Has your child been assessed by a professional for any ***developmental delays?*** Yes No
    Speech and language? Yes No
    Cognitive delays?_____ Other? _____

14. Does your child have an ***Individual Family Service Plan (IFSP) or an IEP?*** ____

15. Does your child receive any special services through a county early childhood special center? If yes, please give the name of the center or facility. _____

16. Would you be willing to share testing results/reports and/or IEP information with our Educational Director?
    Yes No

New students are admitted under a **two week probationary period** during which time TLC staff will evaluate whether the TLC program is developmentally appropriate for your child. We believe it is important for each child to have a positive preschool experience.

Parent's Signature _____ **Date** _____

TLC Child Profile for Four Year Olds

PLEASE PRINT CLEARLY

Child's Name _____ **Date** _____ **Age** ____ **Birthday** _____

You know your child better than any one else in the world! You have observed your child's growth on a day-to-day basis, and you are uniquely qualified to share that with us. Please take time to complete this profile for your child. This information will help us know your child better and meet his/her individual needs.

1. What would you like most for your child to experience at TLC?
   _____
   _____

2. Do you have any concerns about your child's development? If yes, please explain briefly.
   _____
   _____

3. Have you discussed your concerns with your pediatrician? Yes No

4. Is your child toilet trained as evidenced by wearing underwear? Yes No

5. Does your child take naps? ___ How long does your child nap? ___

6. Has your child previously attended a preschool or daycare center? Yes No

7. If yes, why did you leave your previous child care center? _____

8. Has your child been assessed by a professional for any ***developmental delays?*** Yes No
   Speech and language? Yes No
   Cognitive delays?_____ Other? _____

9. Does your child have an ***Individual Family Service Plan (IFSP) or an IEP?*** ____

10. Does your child receive any special services through a county early childhood/special center? If yes, please give the name of the center or facility. _____

11. Would you be willing to share testing results/reports and/or IEP information with our Educational Director?
    Yes No

New students are admitted under a **two week probationary period** during which time TLC staff will evaluate whether the TLC program is developmentally appropriate for your child. We believe it is important for each child to have a positive preschool experience.

Parent's Signature _____ **Date** _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

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

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

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

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

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Disorder	☐	☐	
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	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Disorder	☐	☐	
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:

The Tabernacle Learning Center
Parent Handbook

I have received a Parent Handbook which outlines the policies and guidelines of The Tabernacle Learning Center. I agree to abide by the policies as described in the handbook.

Child's Name (Printed)	Parent's Name (Printed)
Parent's Signature	Date

THE TABERNACLE LEARNING CENTER
11601 South Laurel Drive, Laurel, MD 20708
301-490-5665 FAX 301-490-8014 www.tabernacletlc.com

PHOTO RELEASE FORM

Child's Name _____

I hereby give the Tabernacle Learning Center and their legal representatives and teachers, the right and permission to publish, without charge, photographs taken during the school year at The Tabernacle Learning Center, 11601 South Laurel Drive, Laurel, Maryland 20708.

I GIVE PERMISSION FOR THE FOLLOWING USES ***(Circle Yes or No and Initial)***

Brochures or flyers (promotional literature) **Yes** **No** _____

Bulletin Board in TLC Hall **Yes** **No** _____

TLC Website **Yes** **No** _____

Facebook **Yes** **No** _____

Bridging (Pre-Kindergarten Class) **Yes** **No** _____

Printed Name Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Date: _____