

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: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

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

Name of Health Practitioner

Date

Signature of Health Practitioner

() _____
Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

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: _____

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 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

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

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

| | | | | | |
|--|--|---------------------|---|--|---|
| Child's Name: _____ | | Birth date: _____ | | Sex M <input type="checkbox"/> F <input type="checkbox"/> | |
| Last | | First | | Middle | |
| Address: _____ | | | | | |
| Number | | Street | | Apt# | |
| City | | State | | Zip | |
| Parent/Guardian Name(s) | | Relationship | | Phone Number(s) | |
| | | W: _____ | | C: _____ | |
| | | W: _____ | | C: _____ | |
| Your Child's Routine Medical Care Provider | | | Your Child's Routine Dental Care Provider | | Last Time Child Seen for Physical Exam: |
| Name: _____ | | | Name: _____ | | Dental Care: |
| Address: _____ | | | Address: _____ | | Any Specialist: |
| Phone # _____ | | | Phone _____ | | |

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 (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"/> | |

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

No Yes, name(s) of medication(s): _____

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

No Yes, type of treatment: _____

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

No 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.

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

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

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_dhmh_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.

This Brochure Provides Information About:

- The requirements that State-regulated family child care homes and child care centers must meet,
- Your rights and responsibilities as the parent of a child in regulated care, and
- How and where to file a complaint if you believe your child care provider has violated State child care licensing regulations.

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education (MSDE), Division of Early Childhood Development. Within the Division, child care licensing is the specific responsibility of the Office of Child Care (OCC), Licensing Branch.

All child care facilities must meet minimum health, safety, and program standards set by Maryland law. To remain licensed, facilities must maintain compliance with those standards. Every licensed facility is inspected by OCC at least once each year to evaluate the facility's compliance with child care regulations.

OCC's thirteen Regional Offices are responsible for licensing activities, including:

- Issuing child care licenses;
- Inspecting child care facilities;
- Investigating complaints against licensed child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary to achieve compliance with regulations.

There are two types of regulated child care facilities: family child care homes and child care centers.

Family Child Care Homes and Child Care Centers Must Meet the Following Requirements:

- Have the approval of OCC, the fire department and other local agencies, as required (i.e., zoning, health, and environment).
- Provide care only in the areas of the facility that have been approved for use.
- Have the license issued by OCC posted where it is easily and clearly visible to parents. The license shows:
 - > the maximum number of children who may be present at the same time;
 - > the age groups which may be served; and
 - > the facility's approved hours of operation.
- At all times, each child must be supervised in a manner appropriate to the child's age, activities, and individual needs.
- All areas of the facility used for child care must be clean, well lit, and properly ventilated. Room temperatures should be comfortable.
- If food service is provided, food must be stored, prepared, and served in a safe, sanitary and healthful manner.
- The facility must offer a daily program of indoor and outdoor activities that are appropriate to the age, needs and capabilities of each child.
- An up-to-date emergency information card must be on file and maintained for each child.
- The facility must post an approved emergency evacuation plan and conduct evacuation drills at least monthly.
- Child discipline procedures must be appropriate to a child's age and maturity level and may not include the deliberate infliction of physical or emotional pain. **Corporal punishment of any kind is strictly prohibited.**

ADDITIONAL INFORMATION

The Maryland Child Care Credential Maryland has a voluntary child care credentialing program that recognizes child care providers' education, experience and professional activities at six levels. Credentialed providers are authorized and encouraged to display the seal issued by the MSDE Office of Child Care.

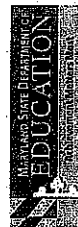


Program Accreditation
Child care programs have the option of becoming state or nationally accredited. Accreditation means that the facility and staff have met program standards of quality.

Child Care and the Americans with Disabilities Act
The federal Americans with Disabilities Act (ADA) requires all child care programs to make reasonable efforts to accommodate children with disabilities. For more information about the ADA, please contact the OCC Regional Office in your area or one of the following organizations:

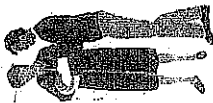
LOCATE: Child Care
Maryland Committee for Children, Inc.
608 Water Street
Baltimore, MD 21202
Phone: (410) 752-7588
www.mdchildcare.org

Maryland Developmental Disabilities Council
217 East Redwood Street, Suite 1300
Baltimore, MD 21202
Phone: (410) 767-3670
(800) 305-6441 (within Maryland)
www.md-council.org



State of Maryland
Martin O'Malley, Governor
Maryland State Department of Education
Nancy S. Grasmick
State Superintendent of Schools
OCC 1524 (rev. 12/2007)

A PARENT'S GUIDE



TO

REGULATED

CHILD CARE

* * *

*Important Information for
Parents of Children in
Child Care Facilities*

A publication of the
Maryland State Department of Education
Division of Early Childhood Development
Office of Child Care

www.marylandpublicschools.org/MSDE/divisions/child_care/child_care.htm

There are certain requirements that apply only to homes or centers.

Family Child Care Homes

- Up to 8 children may be in care at the same time if the home meets certain physical requirements. No more than 2 children under the age of two, including the caregiver's own, may be in care at the same time unless the home has been approved to serve additional children in this age group and an additional adult is present. Under no circumstance may care be provided at the same time to more than 4 children under the age of two.
- Each applicant for a family child care license must:
 - Have a criminal background check and child abuse/neglect clearance;
 - Submit a recent medical evaluation; and
 - Complete pre-service training requirements, including certification in first aid and CPR.

- Each adult resident of the home must also have a criminal background check and child abuse/neglect clearance.
- After becoming licensed, the caregiver must periodically complete additional training. Also, current certification in first aid and CPR must be maintained at all times.
- Each caregiver must have at least one substitute who is available to care for the children in the event of the caregiver's temporary absence from the home. Each substitute is subject to approval by OCC and must have a child abuse/neglect clearance. If paid by the caregiver, a substitute must also have a criminal background check. Before allowing a substitute to provide care, the caregiver must tell the substitute how to reach parents in the event of an emergency and familiarize the substitute with the home's child health and safety procedures.

Child Care Centers

The center director and staff members who have group supervision responsibilities must meet minimum education, experience, and training qualifications. They must also meet continued training requirements each year.

The director and all paid center employees must complete a criminal background check and a child abuse/neglect clearance, and submit a medical evaluation.

In each classroom, staff/child ratios and maximum group size requirements must be maintained at all times. The following table shows some basic age groupings and the applicable requirements:

| Age Group | Ratio | Maximum Size |
|------------------|-------|--------------|
| 0-18 months | 1:3 | 6 |
| 18-24 months | 1:3 | 9 |
| 2 years | 1:6 | 12 |
| 3-4 years | 1:10 | 20 |
| 5 years or older | 1:15 | 30 |

For every 20 children present, there must be at least one staff member who is currently certified in first aid and CPR.

Your Rights and Responsibilities as a Child Care Consumer

- You have the right to:
 - Expect that your child's care meets the standards set by Maryland's child care licensing regulations (NOTE: the regulations are available online at: www.marylandpublicschools.org/MSDE/divisions/child_care/regulat/).
 - Visit the facility without prior notification any time your child is there.
 - See the rooms and outside play area where care is provided during program hours.
 - Be notified if someone in the family child care home smokes. In child care centers, smoking is prohibited.
 - Receive advance notice when a substitute will be caring for your child in a family child care home for more than two hours at a time.
 - Give written permission before a caregiver may take your child swimming, wading, or on field trips.
 - Give written authorization before any medication may be administered to your child.
 - Be notified immediately of any serious injury or accident. If your child has a non-serious injury or accident, you must be notified on the same day.
 - File a complaint with OCC if you believe that the caregiver has violated child care regulations.

Any complaint you make to OCC about the care your child is receiving will be promptly investigated by OCC. Review the public portion of the licensing file for the facility where your child is or has been enrolled, or where you are considering enrolling your child.

How Do I File a Complaint?

If you wish to file a complaint, contact the OCC Regional Office in the area where the child care facility is located. Complaints may be filed anonymously. Listed below are Regional Offices and their main telephone numbers:

- | | |
|--|--------------|
| 1 - Anne Arundel County | 410-514-7850 |
| 2 - Baltimore City | 410-554-8300 |
| 3 - Baltimore County | 410-583-6200 |
| 4 - Prince George's County | 301-333-6940 |
| 5 - Montgomery County | 240-314-1400 |
| 6 - Howard County | 410-750-8770 |
| 7 - Western Maryland | |
| Hagerstown - Main Office | 301-791-4585 |
| Allegany Co. Field Office | 301-777-2385 |
| Garret Co. Field Office | 301-334-3426 |
| 8 - Upper Shore | 410-819-5801 |
| Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties | |
| 9 - Lower Shore | 410-713-3430 |
| Somerset, Wicomico, and Worcester Counties | |
| 10 - Southern Maryland | 301-475-3770 |
| Calvert, Charles and St. Mary's Counties | |
| 11 - North Central | 410-272-5358 |
| Cecil and Harford Counties | |
| 12 - Frederick County | 301-696-9766 |
| 13 - Carroll County | 410-751-5436 |

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated.

If you need additional help, you may contact the main office of the OCC Licensing Branch:

Program Manager, Licensing Branch
 MSDE Office of Child Care
 200 West Baltimore Street, 10th Floor
 Baltimore, MD 21201
 410-767-7805

Dear Parent/Guardian:

Maryland child care regulations require your child care provider to verify that you received a copy of "A Parent's Guide to Regulated Child Care." On the lines below, please write the name of each child you have placed in the care of this provider. Complete and sign the statement at the bottom, tear off and give this portion of the brochure to the child care provider for retention in the facility's files.

Child: _____

Child: _____

Child: _____

Child: _____

I, _____ have received a copy of the consumer education brochure entitled "Parent's Guide to Regulated Child Care."

Date _____

Signature of Parent/Guardian _____

**Immunization Records
and a copy of parent(s)
ID needed!**

\WORLDVIEW CHRISTIAN CENTER
12700 S.E. CRAIN HIGHWAY
BRANDYWINE, MD 20613
301-372-0053

My signature indicates that I have read and thoroughly understand and will abide by what is written in this contract for childcare services at World View Christian Center.

Signature of Parent(s)

Name(s) of Child(ren)

Date

Signature of Director

Date