EMERGENCY FORM

INSTRUCTIONS TO PARENTS/GUARDIANS:
(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/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt# / City / State / Zip Code)

2. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt# / City / State / Zip Code)

3. Name _____ (Last / First) Telephone (H) _____ (W) _____

   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 _____ (Last / First) Birth Date _____

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____ (Street/Apt# / City / State / Zip Code)

Mother/Guardian's Name _____ (Last / First) Home Telephone _____

Employer/School _____ (Name / Address)

Home Address *(If different from above)* _____ (Street/Apt# / City / State / Zip Code)

Work Telephone _____ Cellular Phone _____ Beeper _____

Father/Guardian's Name _____ (Last / First) Home Telephone _____

Employer/School _____ (Name / Address)

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/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

WOODSIDE CHILD CARE CENTER

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Email woodsidechildctr@aol.com
Website: woodsidechildrencare.org

AGREEMENT OF ENROLLMENT

I consent and agree to the enrollment of my child/ren _____ with Woodside Child Care Center, Inc. (WCCC) and/or Summer Camp at Woodside.

I give my consent for my child/ren to take part in field trips, swimming and/or other excursions (including walking trips) sponsored by Woodside Child Care Center and/or Summer Camp at Woodside with proper supervision.

I give my permission/consent for photos/videos of my child(ren) taken by WCCC staff to be used on WCCC's Facebook page and website and as part of the digital frame display.

I agree to pay monthly tuition and any other fees on time as required by WCCC and/or Summer Camp at Woodside. I understand that a $10.00 Late Payment Fee is assessed for any tuition not paid on time and this $10.00 fee is due at the same time that tuition is paid.

I understand that there is a $1.00 per minute Late Pick-Up Fee for children picked up after the center's closing time of 6:30pm (school year) and 6:00pm (summer). I also understand that this fee is to be paid at the time of the late pick-up.

I understand that no deductions or refunds of tuition will be given for absences including our family vacations or child illness or religious observances, or closure of center due to weather, holidays, or other circumstances.

I understand and agree to the WCCC (including Summer Camp at Woodside) Withdrawal Policy which requires two weeks written notice for withdrawal of my child from WCCC afterschool program & summer camp.

I further agree that in case of accident or injury, emergency medical care may be given in the event that I cannot be contacted immediately.

I understand that my child cannot be in care at the center with symptoms of a contagious illness [a fever (100 or higher), diarrhea, vomiting, severe cough, etc.] If these symptoms develop while at WCCC, I am aware that I will be called to pick up my child immediately.

I have included on my child/ren's emergency card how I can be reached in the case of an emergency.

The Center reserves the right to dismiss any child who cannot abide by the rules of the Center and/or who endangers self and/or others while at the Center.

I agree to abide by all of the policies and requirements as stated by the WCCC. I understand these policies may be updated periodically.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Updated 2/6/17

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html *Select DHMH 896.*
- ***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://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

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☐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:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

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: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

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	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

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		
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ 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 IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

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	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

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.

Clinic / Office Name
Office Address/ Phone Number

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: _____

WOODSIDE CHILD CARE CENTER

Quality After School & Summer Camp since 1971
8900 Georgia Avenue
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301-588-0411
Fax: 301-588-2531
Email: woodsidechildctr@aol.com
Website: woodsidechildcare.org

UPDATED 3/12/14

POOL PERMISSION

Please read over and check ALL that apply to your child. We must have a separate completed form for EACH child. Then sign your name & date it at the bottom.

Thanks!

Child's Name: _____

_____ My child cannot swim & may only be in the shallow part (3ft. or less).
UPDATES: (initial & date) _____ _____ _____ _____

_____ My child has some swimming skills & may go beyond the rope of the 3 ft., but not passed 5 ft.
UPDATES: (initial & date) _____ _____ _____ _____

_____ My child is a great swimmer & may go into whatever part of the pool that he/she likes.
UPDATES: (initial & date) _____ _____ _____ _____

_____ My child may also go off of the diving board & slide (both are in the deep end of 7-13 ft.).
UPDATES: (initial & date) _____ _____ _____ _____

_____ _____
Parent/Guardian Signature Date

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UPDATED 2/6/17

SUNSCREEN CONSENT

Summer Camp at Woodside Child Care Center, Inc. has Coppertone Waterbabies and/or Kids SPF 50 available to apply on children for swimming and other outside activities. If you give us permission to use this brand of sunscreen on your child(ren), please fill in the appropriate information below and return this form to our office.

If you prefer your child(ren) to use a sunscreen other than Coppertone Waterbabies and/or Kids SPF 50, please check the box below and sign and date. We ask that you be sure that your child has the preferred sunscreen in their bag and fill in the name of the preferred sunscreen on the blank provided. Also, the sunscreen should be labeled with your child(ren)'s name.

Thank you,
WCCC

CHILD'S or CHILDREN'S NAME (S): _____

____ Yes, I give my permission for my child to use WCCC's Coppertone Waterbabies and/or Kids 50 sunscreen. I also give my permission for WCCC staff to apply it on my child(ren) if my child(ren) need assistance.

_____
Signature of Parent/Guardian Date

____ No, I will provide a different sunscreen for my child(ren) to apply on themselves.

_____
Name of child's personal Sunscreen

_____
Signature of Parent/Guardian Date