



New Life Christian Academy Enrollment Package

13711 Annapolis Road, Bowie, MD 20720

301-352-5433

Hours of Operation: 6:45 am – 6:30 pm

www.newlifecommunitychurch.com

Welcome to New Life Christian Academy!

The purpose of this handbook is to outline the policies and procedures under which we operate. We give the children in our care opportunities to learn where they feel safe and loved, and can begin to build a positive self image. Your child will have the opportunity to gain practice in language, fine motor, large motor & self-help skills. Your questions and comments are important so we can achieve the very best experiences for your child.

We are always open to suggestions and feel communication is an essential part of this ministry. If there are any problems or concerns, we encourage you to talk to us about it. If a lengthy conference is needed, a time that is convenient to all parties will be scheduled, as the other children still need our attention during operational hours. Thanks you for the opportunity to serve your family through this ministry and look forward to the future.

NEW LIFE CHRISTIAN ACADEMY

13711 Annapolis Road, Bowie, MD 20720

301-352-5433

**ENROLLMENT REGISTRATION
INFORMATION**

CHILD INFORMATION

Name of Child (Last, First, Middle Int.): _____

Nickname: _____ Age: _____ Sex: _____ DOB: _____

Child's Primary Language: _____ Parent/Guardian's Primary Language: _____

Home Email Address: _____ Home Phone: _____

Child's Home Address: _____

Parent/Guardian Marital Status: Single Married Divorced Widowed Primary Residence: Mother Father Both Guardian: _____

List the family members your child lives with-include names and ages of siblings: _____

Circle Days to Attend: AM Mon Tues Wed Thurs Fri

Arrival Time: _____ Departure Time: _____

PM Mon Tues Wed Thurs Fri

Arrival Time: _____ Departure Time: _____

PRIMARY CONTACT & RELEASE FORMS

Parent/Guardian #1: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

Parent/Guardian #2: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

Name of Child: _____ Parent / Guardian Signature: _____

EMERGENCY CONTACT AND RELEASE PERSONS

Please notify the center if an Emergency Release Person will pick up your child on a given day. For the safety of your child, we will request all authorized release persons to provide Government-issued photo identification at the time of pick-up. All persons below must be 18 or older, unless he/she is the parent of the child.

Name #1: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
Home Address: _____ Home Email Address: _____
Driver's License Number / State: _____
Work Phone/Extension: _____ Work Hours: _____

Name #2: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
Home Address: _____ Home Email Address: _____
Driver's License Number / State: _____
Work Phone/Extension: _____ Work Hours: _____

Name #3: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
Home Address: _____ Home Email Address: _____
Driver's License Number / State: _____
Work Phone/Extension: _____ Work Hours: _____

The persons designated in this section will be contacted and are authorized to pick up my child if there is a medical or other emergency and I can not be reached. Parent/Guardian must complete any state-specific emergency release form required by individual state child care licensing regulations.

- The School staff will release your child only to you or to those persons you have listed above. Emergencies may prevent you from picking up your child; therefore, include those individuals whom you would authorize in such events. If you want a person who is not identified above to pick up your child, you must notify school staff in advance in writing. Your child will not be released without prior authorization. In the event you call a pick-up authorization into the school because you are unable to submit your authorization in writing, we will use your personal information to verify your identity. Please notify emergency contacts that a government-issued photo ID must be presented to school staff.
- If you must pick up your child after closing time, you will be charged a late fee per every 15 minutes or portion of 15 minute period, per child, until the child is picked up. Per state licensing regulations, we may be required to contact local authorities after a certain amount of time. Please contact the Director for additional information.

CHARGES AND PROCEDURE FOR LATE PICK-UP: A late fee of ten dollars (\$10.00) for the first 15 minutes will be charged per child beginning at 6:45 pm and an additional fee of \$1.00 per minute will be added for any child remaining after 6:46 pm.

Examples: 6:31-6:45 = \$10.00 late fee 6:46=\$11.00 late fee

These fees will be charged for each child. The fee is to be paid in cash only to the staff member on duty at the time of pick-up. If late fee is not received at time of pick-up a \$10.00 fee will be assessed daily until payment is received.

RETURNED CHECKS: I understand that a processing fee will be charged to my account for all checks which are returned for any reason, and this fee is in addition to any charges that my bank or financial institution may charge me. I understand that any non-sufficient funds checks will be automatically resubmitted electronically up to three times. I further understand that once a check has been processed electronically, the check is no longer negotiable and will not be returned. If more than two checks are returned within a six month period, I will be required to pay by an alternate method of payment for the next six month period.

DAILY PROCEDURE

DAILY SIGN-IN AND SIGN-OUT: I agree to sign my child in and out every day using the school's attendance procedure. I understand that I am required to enter the school to drop off and pick up my child and that I must escort my child to and from the designated classroom and staff member each day.

ILLNESS: I understand that I will be notified should my child becomes ill during the day, and that I will pick up my child promptly, or make arrangements for an authorized emergency contact person to pick up upon such notification. If my child is exposed to or contracts a contagious disease, I agree to notify the school and I understand that my child will be re-admitted according to the Re-admission Criteria in the Family Handbook.

Please do not bring your child to the daycare when they have the following illnesses or symptoms.

1. Severe or persistent coughing
2. Constant runny nose with green or yellow mucus
3. Fever (100 F and higher)
4. Vomiting
5. Yellowish skin or eyes
6. Unusual spots or rashes that have been checked by a physician
7. Infected patches
8. Diarrhea
9. Gray or white stool
10. Unusual dark, tea-colored urine
11. Sore throat or trouble swallowing
12. lethargic, listlessness (child not feeling themselves)
13. Lice, nits or untreated ringworm
14. communicable diseases (chicken pox, conjunctivitis (pinkeye), mumps, measles, influenza)
15. Discharge from eyes or ear

WITHDRAWAL FROM PROGRAM: I understand that I must provide a two (2) week written notice of withdrawal from the program. If this notification is not provided, I agree to pay all tuition and fees for two (2) weeks, whether or not my child attends. I understand that when my child is withdrawn, she/he will only be eligible for re-admission based upon space availability and all other enrollment criteria.

CHILD ABUSE: We are required by law to report to the local Social Services Office any suspected physical, emotional, sexual or suspected abuse or neglect.

BEHAVIOR MANAGEMENT AND DISCIPLINE: No physical punishment will be used. Discipline is enacted on an individual basis. In many cases the word "NO" dissolves the problem. If a child does not listen, talks back. Etc., the child will be placed in a time out to think about their actions. If your child in endangering other children (hitting, kicking, biting or scratching) they will be turned over to the daycare director and the parents will be notified. We will decide on the appropriate disciplinary action, which may include but is not limited to timeouts, restriction from activities, suspension or expulsion. Sometimes if both a parent and a provider are in the same are at the same time, a child may forget the rules, or test the boundaries. Please help show your child that you respect us, the rules of our center, and our property by reminding them that the rules still apply when you are around. We will also remind them of the rules and correct them if needed.

_____ **NAP TIME / REST TIME:** All children under the age of 5 are **required** by Maryland State law to have a rest period. No child is forced to sleep; however they must remain quiet. Parents are required to provide two (2) coverings for their child to use on their rest mats, cots, or cribs. One covering will be used for your child to lie upon and the other covering will be used for warmth. **This as a regulation required by the State of Maryland.** All coverings will be sent home on Friday's for laundering and must be returned on Monday mornings at the time of drop off.

_____ **FIELD TRIPS:** Several field trips and in-house events are planned throughout the year. There will be a small fee for each activity. A signed permission slip will be required for all trips.

_____ **CLOTHING & OUTDOOR PLAY:** Your child's clothing should be loose and comfortable and easily managed. High top sport shoes are quite difficult to maneuver. We recommend Velcro closure for children who have not mastered shoe tying. Sturdy shoes are needed for safe play on outdoor equipment. Please no sandals or flip-flops. We play outdoors every day (weather permitting); please dress your child appropriately. All clothing should be labeled with your child's name. The school cannot be responsible for lost clothing.

_____ **MEDICATIONS:** We are not permitted to dispense any medication without a written order from a parent. Forms are available if needed. Medication will be administered between noon and 1:00 pm only.

_____ **BIRTHDAY CELEBRATIONS:** Your child is welcome to celebrate his or her birthday with the class. Please consult with the teacher to schedule a party. You may send cookies, cupcakes or ice cream etc... Balloons, gifts and special entertainers may not be included in your plans. If you are planning a party away from the center, we ask that invitations be mailed unless the entire class is invited.

HOLIDAYS, ABSENCES AND CLOSINGS

_____ **HOLIDAYS:** I understand that the school is closed on the following days:

President's Day

Good Friday

Easter Monday

Memorial Day

Independence Day

Columbus Day

Christmas Day

Day after Christmas

New Years Eve closing @ noon

New Years Day

Martin Luther King Day

Labor Day

Veterans Day

Thanksgiving Day

Day after Thanksgiving

Christmas Eve closing @ noon

I agree that I will not receive a refund, credit or any other allowance for holidays. If a holiday falls on a weekend, it will be observed on either the preceding Friday or the following Monday. *Please note that if the daycare is closed on a Monday all tuition payments must be made the Friday before the closing to avoid late fee.*

_____ **ABSENCES/VACATIONS:** I agree to inform the school immediately if my child will be absent on any day. I understand that no allowances, credits, refunds, or make up days shall be made for occasional absences (i.e. sickness). A reservation fee of 50% of my regular week's tuition will be due for each absence of one full school week (Monday through Friday) with advance notice to the Director, if possible. My reservation fee will be \$_____ per week to guarantee my child's space when my child is not in attendance.

_____ **INCLEMENT WEATHER OR OTHER DISASTERS:** I understand that the school will follow the PG County Public School closing schedule for inclement weather. If PG County Schools are open two (2) hours late, then NLCA will be open at 8:45 am. If PG County Schools are going to close early due to inclement weather, then I will be required to contact the school to see what time I will need to pick my child up by. I agree that in the event that the school is closed for an extended period of time, I will continue to be responsible for my tuition payments for up to three business days. Should the school be closed on a tuition payment day, I understand that my tuition will be due on the following business day should the school be open.

We do not discriminate based on disability in the admission/enrollment or access to our programs or services. Information concerning the provisions of the Americans with Disabilities Act (ADA), including the rights provided hereunder, is available from the Director.

These policies have been reviewed with me by school management. I understand and will comply with the policies. The policies in this contract will supersede all other previous documents.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

Name of Child: _____

ENROLLMENT REGISTRATION INFORMATION

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

In the event of an emergency requiring a physician's care, would you like us to call your family physician?

Yes _____ No _____ If yes, please provide the following information:

Physician's Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I (we) _____ and _____, do hereby state that I am (we are) parent(s)/legal guardian(s) of _____, a minor child age _____, born on _____, who resides with me (us) at _____.

I (we), _____ authorize, for emergency purposes only, a school-designated employee to transport the above minor by ambulance and consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the minor under the general supervision of any physician or surgeon licensed to practice medicine in the State of _____.

Last Tetanus/Diphtheria Booster: _____

Allergies to drugs, foods or other: _____

Please list any special medications or pertinent information: _____

Parent/Guardian signature: _____

Appeared before me and produced _____ as identification. Date: _____

Director Signature: _____ Print name: _____

AUTHORIZATION FOR TRANSPORTATION, FIELD TRIP OR EMERGENCY

We may plan special field trips for the children away from the school. These trips are carefully arranged and shall be supervised by an adequate number of adults. This includes children taking walks and infants strolling in their buggy. You will always receive advanced notice of ALL field trips. We have your permission to take your child, _____, on these field trips.

For emergency purposes, we have permission to evacuate the premises. Our emergency evacuation site is posted in each school.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

PARENTS/GUARDIANS OF CHILDREN AGES 4 YEARS OLD AND OLDER ONLY:

We have permission to pick up your child, _____, on a daily basis from _____ school and take him/her on field trips.

Transportation off-school grounds is only provided for children at least 4 years old and 40 pounds or more. By signing this, you are certifying that your child is at least 4 years old and 40 pounds or more.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Name of Child: _____

Date: _____

Parent/Guardian Initial _____

ENROLLMENT REGISTRATION INFORMATION

MEDICAL INFORMATION

MEDICAL HISTORY

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Distinguishing Marks: _____ Date of Birth: _____

1. Medication that will be administered regularly at the school: _____

2. Special Dietary Needs: _____

3. Is your child able to walk? Yes No Explain: _____

4. Can your child effectively communicate his or her needs? Yes No Explain: _____

5. Is your child toilet trained? Yes No

Please provide special instructions concerning any other illnesses, as necessary _____

Allergies (please check and list all that apply)

Medications Reaction: _____

Food Reaction: _____

Other: _____ Reaction: _____

Are any of the allergies severe or life-threatening? Yes No If yes, please provide special instructions: _____

MEDICAL CARE PROVIDER/FACILITY

I hereby give consent for the facility to secure any and all necessary emergency medical care for my child. In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child and seek medical attention.

Parent/Guardian Initials: _____ Date: _____

Primary Care Physician Name: _____ Practice/Clinic Name: _____

Address: _____ Phone: _____

Preferred Hospital/Clinic for Acute Care and Emergency Care: _____

Dentist Name: _____ Practice/Clinic Name: _____

Address: _____ Phone: _____

Health Insurance Provider and Policy Number: _____

Secondary Health Insurance Provider and Policy Number: _____

Per state regulations, a written statement is required for waiver of immunization requirements.

Name of child: _____

Parent/Guardian Initial _____

ENROLLMENT REGISTRATION INFORMATION

CHILD PROFILE

Child's Name: _____ Age: _____ Date: _____

You know your child better than anyone else in the world! You have observed your child on a day-to-day basis and are uniquely to share your insight about your child's development with us. Please take a moment to complete this profile, as the information will help us know your child better and to meet his or her individual needs.

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

2. What does your child enjoy doing the most?

3. What are your child's favorite toys?

4. With whom does the child reside? Please list names and relationships to child and names and ages of other children:

ADULTS: Name:	_____	Relationship:	_____
Name:	_____	Relationship:	_____
Name:	_____	Relationship:	_____
CHILDREN: Name;	_____	Age:	_____
Name:	_____	Age:	_____
Name:	_____	Age:	_____

5. Who also cares for your child(ren)? _____

6. What language is spoken in your home? _____

7. Does your child have any medical or physical needs? Explain:

8. Does your child have any allergies? Explain:

9. What are the foods your child likes best? _____

Least? _____

10. What are your child's mealtime routines at home? _____

11. How many hours of sleep does your child receive at night? _____

12. Does your child need to be awakened in the morning to attend the school? _____

13. What are your child's sleeping arrangements? Check appropriate answer.

Own room Shares room with _____ Sleeps in _____ Sleeps in bed

14. What are your child's bedtime rituals? _____

Name of Child: _____

Parent/Guardian Initial _____

ENROLLMENT REGISTRATION INFORMATION

15. Does your child take naps? C Yes No How long? _____
16. Does your child need a favorite item (such as a blanket) for a nap? D Yes IJ No
If so, does your child have a special name for it? _____
17. What words are spoken in your house for toileting? _____
18. How does your child express anger or react to frustration? _____
19. Does your child have any particular fears? _____
20. How does your child react to change (such as being left by parents)? _____

21. How does your child comfort himself/herself? _____
22. What are your child's play interests (preference for creative, dramatic or construction play)? _____

23. How do you discipline your child? _____

24. When did your child begin to use language? _____
25. How would you describe your child (personality characteristics)? _____

26. What do you enjoy the most about your child? _____
27. Is there anything else in your child's experience you would like to tell us so we can better meet your child's needs?

28. Has your child had previous preschool experiences? _____
29. Are you available to help us with field trips or other special events? _____
30. Do you have a special interest or hobby you would like to share with the children? _____

Parent/Guardian Signature: _____ Date: _____

Name of Child: _____

Parent/Guardian Initial _____

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN**

CHILD'S NAME: _____

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

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

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

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

Signature of Parent/Guardian

Date

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

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

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

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

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

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO
 If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.
 YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO
 If YES, please specify: _____

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

8. Does this child's physical activity need to be restricted? YES NO
 If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO
 If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO
 If YES, please specify type: _____
 Special instructions for use: _____

RECORD OF IMMUNIZATIONS

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

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

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

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

Signature of Health Practitioner _____

Date _____

Phone Number _____

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

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. **If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

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

CERTIFICATION INFORMATION'

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

"A school principal or other person in charge of a school, public or private, may not knowingly admit a student to, or retain a student in a: 1) preschool program unless the student has furnished evidence of age-appropriate immunity against Haemophilus influenzae type b 2) preschool program or kindergarten through the second grade of school unless the student has furnished proof of age appropriate immunity against pertussis; and 3) preschool program through the twelfth grade unless the student has furnished evidence of age-appropriate immunity against tetanus, diphtheria, poliomyelitis, measles (rubeola), mumps, rubella, hepatitis B and varicella"

Please refer to the "IVEnimum 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 DHMH COMAR 1046.04.03 are available at www.edcp.org (click "Immunization").

The requirement for hepatitis B and varicella vaccine is a "progressive" regulation in which each new school year another successive grade becomes covered by the regulation (e.g., kindergarten in 2001, grade in 2002, etc.).

Age-appropriate immunization requirements for licensed child care centers and family day care homes are based on the "Maryland DHMH Recommended Childhood Immunization Schedule". Please refer to Department of Human Resources COMAR 07.04.02.44 and COMAR 07.04.01.29 for day care regulations. DER COMAR regulations and the 'Maryland DHMH Recommended Childhood Immunization Schedule' are available at www.edcp.org (click "Immunization").

HOW TO USE THIS FORM

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by **signing** or stamping the signature section. A different medical provider, a local health department official a school official, or a day 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 day care service.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **measles, mumps, or rubella.**

Reconstructed dates for all vaccines must be reviewed and approved by the local health department.

Blood test results are NOT acceptable evidence of DTP/DTaP/DT/Fd immunity.

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.**

2. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME			
S	LAST	FIRST	MI
SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	BIRTHDAY / /		GRADE
COUNTY		SCHOOL	
PARENT OR GUARDIAN NAME		PHONE NO.	
ADDRESS		CITY ZIP	

RECORD OF IMMUNIZATION : See Notes

AGE	VACCINE TYPE					DOSE	VACCINE TYPE			
	DTP-13111 MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Rib MO/DAY/YR	Ho B MO/DAY/YR		M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	ItunELLA MO/DAY/YR	MUMPS MO/DAY/YR
2						2				
3						nose.	Varicella MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR
4						1				
5						2				

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

1. Signature _____ Title _____ Date _____

2. Signature or Initial _____ Title _____ Date _____

3. Signature or Initial _____ Title _____ Date _____

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

LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department. See

Notes) I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed _____ Date _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health. This is a permanent condition temporary condition until _____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed _____ Date _____
Physician or Health Official

BELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona tide religious beliefs and practices, I object to any immunization being given to my child.

Signed _____ Date _____

DgmE 896, Rev. 4/01

Center for Inuunitization: www-edcp.org