Dear Parents,

I (Parent Name) ___________________________________ give Little People's Educare permission to take photos of (Child's Name)______________________________________to only go on our websites/ Facebook account. We of Little People's Educare give our word that your child pictures will be only used for our website nothing else.

I (Parent Name) ___________________________________ do not give Little People's Educare permission to take photos of (Child's Name)______________________________________to only go on our websites/ Facebook account. We of Little People's Educare give our word that your child pictures will be only used for our website nothing else.

Website: Little People's Educare/Facebook

www.littlepeoplesedcaure.com

Parent Signature: ___________________________________

Date:___________________

Thank You

Little People's Educare

September 17, 2013

Dear Parents,

It is very important to know and beware of our children allergies. We are asking you to briefly take the time and write down your child/children allergies. This would keep our children safe and healthy.

Childs Name: ______________________________

Allergies:
____

____

Thank You

Little People's Educare

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

Child's Name: ____________________________________ Birth Date: ____________________
Last First Middle

Name of Parent/Guardian: ______________________________ Relationship: ____________________

Home Address: ____
Street City State Zip Code

Home Telephone: ____

Dear Parent/Guardian:

Every child should have medical and dental health supervision from birth to age 18. Even healthy children should see a doctor and dentist at regular intervals. Health check-ups should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

Maryland law requires you to submit proof of age-appropriate immunizations on the Maryland Immunization Certificate (DHMH 896) to the center, home, or school. This must be done before your child can be admitted.

This form requests health information from you (Part I) and from your child's Health Practitioner (Part II). The section you complete will be helpful to the Health Practitioner in his evaluation of your child.

It is necessary that you provide information for this Form 1214. This is the Emergency Information Form for Child Care Centers, Family Child Care Homes, and Non-Public Nursery Schools and Kindergartens.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: ____
Child Care Center, Family Child Care Home, School

Address: ____
Street

____
City State Zip Code

PART I: CHILD'S INFORMATION

To be completed by **PARENT/GUARDIAN**

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 (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?*	____	____
2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?*	____	____
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 (*frequent earaches, difficulty hearing, etc.)*?	____	____
Date of last hearing evaluation ____/____/____ Doctor's Name: ____________		
Results: ____________		
Does your child use a hearing aid?	____	____
4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.*)?	____	____
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, give details under "Remarks".	____	____
(a) Does this condition require any special health care in the child care facility or school?	____	____
(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or education needs? If YES, give details under "Remarks".	____	____
(c) Does your child require any adaptive equipment?	____	____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or school teacher should know about? If YES, give details under "Remarks".	____	____

REMARKS *(Clarify any "YES" answers):*

PARENT'S STATEMENT – ALL MUST SIGN AND DATE BELOW

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 AND EDUCATIONAL NEEDS IN CHILD CARE OR SCHOOL.

Please fill in, if child is school age:

I give my permission to ____________ School to release ____________
Name of Child

Health information to ____________
Name of Child Care Center, Family Child Care Home, Non-Public Nursery School

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

2. This child has the following which may significantly affect his/her child care or educational 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: ______________________________

3. This child has a health condition which may require care or emergency action while at child care/school. _____YES _____NO

   Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): ______________________________

   Recommendations: ______________________________

4. 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: ______________________________

5. This child requires a modified diet and/or special feeding procedures. _____YES _____NO

   If YES, please specify: ______________________________

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

6. 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?

   ____

7. Does this child's physical activity need to be restricted? _____YES _____NO

   If YES, please specify: ______________________________

8. Does this child require any specialized treatment? _____YES _____NO

   If YES, please specify: ______________________________

9. Does this child require any adaptive equipment (braces, crutches, etc.)? _____YES _____NO

   If YES, please specify type: ______________________________

   Special instructions for use: ______________________________

10. Additional comments: ______________________________

HEALTH PRACTITIONER'S STATEMENT

I conducted a physical examination of the above-named child on ________________ and find that he/she IS / IS NOT medically cleared to attend child care or school.
(circle correct response)

______________________________ ( ) ______________________________
Name of Health Practitioner (*Please Print*) Telephone Number

______________________________ ______________________________
Signature of Health Practitioner Date

PART III – ADDITIONAL COMMENTS

This page is to be used by child care personnel to record signs of illness or accidents observed by the staff and to record when the parent was notified.

It may be used to record reasons for absences and other information related to the child's health status.

Written recommendations by health practitioner or parent following absences may be attached to this record.

DATE	RECORDER	DETAILS

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.

When parents 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's Name ______ Last ______ First ______ Home Telephone ______

Mother's Employer/School ______ Name ______ Address

Mother's Home Address *(If different from above)* ______ Street/Apt.# ______ City ______ State ______ Zip Code

Work Telephone ______ Cellular Phone ______ Beeper ______

Father's Name ______ Last ______ First ______ Home Telephone ______

Father's Employer/School ______ Name ______ Address

Father's 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:

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 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 IMMUNIZATION (See Notes)

VACCINE TYPE							VACCINE TYPE				
DOSE #	DTP-DTaP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	PCV7 MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1							1				
2							2				
3							DOSE #	Varicella MO/DAY/YR	History of Varicella Disease Date - MO/YR	OTHER____ MO/DAY/YR	OTHER____ 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
(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.

Office Stamp

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the 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 above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ______/______/______

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

Signed: ______________________________ Date ______________
Physician or Health Officer

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.

Signed: ______________________________ Date: ______________

HOW TO USE THIS CERTIFICATE OF IMMUNIZATION

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 the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

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

Notes:

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

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

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

CERTIFICATION INFORMATION

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

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization). The requirement for hepatitis B and Varicella vaccine is a "progressive" regulation in which another successive grade(s) become covered by the regulation with each new school year.

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 07.04.01.29A, 07.04.02.44A and COMAR 07.04.05.34A. DHR COMAR and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guidelines chart are available at www.EDCP.org (Immunization).