CACFP Enrollment : Yes:_____No:_____
Days & Hours : Mon___Tues__Wed__Thurs___Friday___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ____________________ Date of Birth: ____________________

Medical Condition(s): ____________________

____

Medications currently being taken by your child: ____________________

____

Date of your child's last tetanus shot: ____________________

Allergies/Reactions: ____________________

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ____________________

____

(2) If signs/symptoms appear, do this: ____________________

(3) To prevent incidents: ____________________

____

- - - - - - - - - - - - - - - - - - - -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ____________________

____

____

____

COMMENTS: ____________________

____

____

____

____

Note to Health Practitioner:

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

____________________ Name of Health Practitioner

____________________ Date

____________________ Signature of Health Practitioner

(_____)____________________ Telephone Number

Essential Personnel School Age (EPSA) Child Care/ Essential Personnel Child Care (EPCC) Programs Family Enrollment Application

2020

MARYLAND STATE DEPARTMENT OF EDUCATION

Parent or Guardian must qualify as <u>essential personnel</u> under the Governor's Executive Order.

Child's Name: _____ **Date of Birth**: ____/____/____

Child's Name: _____ **Date of Birth:** ____/____/____

Child's Name: _____ **Date of Birth:** ____/____/____

Home Contact Information:

Street Address: _____

City: _____ **State:** _____ **Zip code:** _____

Cell Phone Number: _____

Work Contact Information:

Name of Agency: _____

Street Address: _____

City: _____ **State:** _____ **Zip code:** _____

Best way to contact you during work hours: _____

Parent/Guardian Information:

Name: _____	Name:_____
Relationship: _____	Relationship:_____
Address: _____	Address:_____
E-mail Address: _____	E-mail Address:_____
Home Phone: _____	Home Phone:_____
Company Name:_____	Company Name:_____
Company Phone: _____	Company Phone: _____

Essential Personnel School Age (EPSA) Child Care/ Essential Personnel Child Care (EPCC) Programs Family Enrollment Application

2020

MARYLAND STATE DEPARTMENT OF EDUCATION

Days of Child Care Service Desired (check all that apply):

MON _____ TUE _____ WED _____ THU _____ FRI _____

Hours of Child Care Service Desired (check all that apply):

MON _____ TUE _____ WED _____ THU _____ FRI _____

Please initial the following.

_____I agree to have the temperature taken of my child(ren) arriving to the building with a temporal thermometer.

_____I agree to remove my child from care if a fever is identified upon arrival to site.

_____I agree to limit contact by limiting inside access and will drop off and pick up my child at the door.

_____I agree to practice social distancing the best way possible, within the setting.

_____I agree that the facility is not charging me any additional fees or tuition for my child(ren).

_____I agree to be charged the full tuition rate charged by this program if I am found to not qualify for the State of Maryland EPSA/EPCC programs by not being essential personnel under Governor Larry Hogan's Executive Order.

I hereby agree to abide by the terms and conditions as provided in this Emergency Personnel School Age (EPSA) Child Care/ Essential Personnel Child Care (EPCC) Programs Family Enrollment Application. At least one parent/guardian of the child(ren) is designated essential personnel. I understand that any violation of the aforesaid terms and conditions may result in termination of enrollment of my child(ren).

Parent/Guardian Name (Please Print): _____

Parent Signature: _____

Date: _____/_____/__2020__

Facility Director/ Designee Name (Please Print): _____

Facility Director/ Designee Name Signature_____

Date: _____/_____/__2020__

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH HISTORY FORM

For Use in Drop-In Child Care Centers*

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____ Relationship: _____

Check the correct answers to the following questions. Give a brief explanation under COMMENTS for any YES answer.

Does the child have any of the following?	YES	NO	COMMENTS
a) Vision problem?			
b) Hearing problem?			
c) Speech or language problem?			
d) Physical illness or impairment problem?			
e) Mental, emotional or behavioral problem?			
f) Developmental delay?			
g) Allergies?			
h) Other? *(If YES, specify)*			
i) Health condition which may require care or emergency action? *(If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.) Attach plan for addressing incidents should they arise.*			
j) Does the child have up-to-date immunizations?			
k) Is the child currently taking any medication?			

This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities.

YES	NO

List any areas of the program in which the child cannot fully participate. Would any limits or alterations help to meet his or her needs? Please explain briefly.

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

* A parent may object when medical examination of a child conflicts with the parent's bona fide religious belief and practice. Under such circumstances, the parent may also use this form.

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child's Picture (Optional)

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions: _____

Medication shall be administered from: _____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE