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Summer Camp Forms 2018 - 2019 – Maryland

Programs Required Forms

- Maryland Office of Child Care Emergency Form
- Maryland Department of Health and Hygiene Immunization Certificate
- Maryland State Department of Education Office of Child Care Health Inventory
- Wonders General Authorization & Release Form
- Wonders Household Demographic Form
- Wonders Emergency Medical Treatment Form
- Wonders Dismissal Authorization Form
- Wonders Family Custody Form

Forms to be completed as needed

- Maryland State Department of Education Office of Child Care Medication Administration Form
- Wonders Babysitting Release Form

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

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.

Clinic / Office Name
Office Address/ Phone Number

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.

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: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by 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.

Immunization Requirements

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; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

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.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

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://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.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://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/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.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☐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:

Where do you usually take your child for routine medical care? Name:

Address: **Phone Number:**

When was the last time your child had a physical exam? Month: Year:

Where do you usually take your child for dental care? Name:

Address: **Phone Number:**

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	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, 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://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.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: ☐Yes ☐ No		

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

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 BY ZIP CODE

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219

Baltimore (cont)
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781

Prince George's (cont)
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

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General Authorization & Release Form

Child's Name: _____

PHOTOGRAPHS: I authorize Wonders to photograph and/or record audio and video of my child while he/she is participating in Wonders programs and activities. I further authorize Wonders to print, publish or otherwise disseminate such photograph(s) and/or audio and video of my child via printed materials, classroom or other Wonders on-site displays, any website operated or maintained by Wonders (e.g., www.wonderslearning.org), or by other means. I understand that such dissemination shall be for the purpose of furthering the educational and/or to promote Wonders.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

FIELD TRIPS: I authorize my child to participate in the Wonders field trip program. I understand that my child may be transported in Wonders activity buses, parent vehicles, school buses, public transportation, or other vehicles, or may walk, depending on the circumstances of the specific trip. I understand that all field trips and corresponding transportation will be supervised by Wonders staff. I understand that this authorization shall apply to all field trips.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

APPLICATION OF SKIN PROTECTION: To protect our children from the sun, we ask that you apply sunscreen on your child each morning before they arrive at school. In the event that you forget to apply it before coming to school we ask that you apply it to your child before you leave the center. Wonders staff will re-apply sunscreen before afternoon outdoor/playground time. For ECE Programs, NAEYC authorizes application of sunscreen only once daily. To avoid any concerns related to possible allergies, individual sunscreens with UVB and UVA protection of SPF 15 or higher must be sent from home, labeled with your child's name to be safely stored at Wonders. I authorize the staff of Wonders to apply non-prescription skin protection (sunscreen, skin lotion or lip balms) on my child as needed
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

APPLICATION OF INSECT REPELLENT: To protect our children from insects, Wonders staff will apply insect repellent before children go outdoors. For ECE Programs, NAEYC authorizes application of insect repellent once a day and requires that only repellent containing DEET be used. We are not allowed to apply any herbal or Homeopathic insect repellent. To avoid any concerns related to possible allergies, individual insect repellents must be sent from home, labeled with your child's name to be safely stored at Wonders. I authorize Wonders to apply non-prescription insect repellent once daily.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

For ECE Programs ONLY
TOOTH BRUSHING: NAEYC requires that all childcare settings provide tooth brushing opportunities to all children who are offered two or meals per day while in our care. Children will brush their teeth with direct supervision of their teachers using toothpaste with fluoride as approved by the American Dental Association. Parents will provide a new, individually labeled toothbrush every three months. Parents will also provide a new toothbrush if the child contracts any contagious illness. I authorize Wonders to offer the opportunity for my child to brush his/her teeth on a daily basis.
[ ] I AUTHORIZE [ ] I DO NOT AUTHORIZE

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

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HOUSEHOLD DEMOGRAPHIC FORM

Child's Name: _____

The following information is requested so we may get to know and understand your child and family. All demographic information on this form is confidential and will be available only to the Director and Wonders Administrators. Consolidated demographic data from this form may be used to seek grants and to inform marketing and fundraising efforts. **This information will not be used in any way to determine eligibility in placement of your child in our programs.**

Child's Date of Birth: _____ Place of Birth: _____
Nickname(s): _____
Is your child adopted? [ ] Yes [ ] No [ ] Domestic adoption [ ] Foreign adoption
Does he/she know? [ ] Yes [ ] No Age of child at time of adoption_ _____
How is adoption discussed at home? _____
_____
How long have you lived in the D.C. area? _____
Language(s) spoken at home: _____
Child's primary language: _____
Other languages spoken by child: _____
Family Religion(s): _____

Household members - List members of the household(s) where the child lives and place a (*) beside those who have a significant role in caring for your child.

Name (as used by child)	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you participate in any religious or cultural observance that might restrict your child's diet at the Center? _____
Date(s) of observance(s) this year: _____
Please list any dietary restrictions during this time_____
How can we support your child during these observations? _____
What are your child's favorite books? _____
What are your child's favorite activities? _____
Does your child have an IEP or a 504 Plan? [ ] Yes [ ] No If yes, please attach
List any developmental, speech, language, hearing, sight or physical and therapy/treatment plans
_____
_____
Is there anything else you would like us to know to better care for your child _____
_____

Family Ethnic Background

	Child	**Parent/ Guardian 1**	**Parent/ Guardian 2**
Asian/Pacific Islander	[ ]	[ ]	[ ]
American Indian/Alaskan Native	[ ]	[ ]	[ ]

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Black	[ ]	[ ]	[ ]
Hispanic	[ ]	[ ]	[ ]
Multiracial	[ ]	[ ]	[ ]
White	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]

Parent/Guardian 1 **Place of birth:** _____

[ ] Mother [ ] Father [ ] Stepmother [ ] Stepfather [ ] Other: _____
[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Age		**Degree(s) received**	**Institution**
[ ] 20-25	[ ] 41-45	[ ] B.A./B.S.	_____
[ ] 26-30	[ ] 46-50	[ ] M.A./M.S.	_____
[ ] 31-35	[ ] 50 or over	[ ] Ph.D.	_____
[ ] 36-40		[ ] J.D.	_____
		[ ] M.D.	_____
		[ ] Other: _____	_____

Place of work: _____ [ ] Full time [ ] Part time
Occupation: _____ Job title: _____
Does your employer have a matching gift program for charitable donations?
[ ] Yes [ ] No [ ] I don't know

Parent/Guardian 2 **Place of birth:** _____

[ ] Mother [ ] Father [ ] Stepmother [ ] Stepfather [ ] Other: _____
[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Age		**Degree(s) received**	**Institution**
[ ] 20-25	[ ] 41-45	[ ] B.A./B.S.	_____
[ ] 26-30	[ ] 46-50	[ ] M.A./M.S.	_____
[ ] 31-35	[ ] 50 or over	[ ] Ph.D.	_____
[ ] 36-40		[ ] J.D.	_____
		[ ] M.D.	_____
		[ ] Other: _____	_____

Place of work: _____ [ ] Full time [ ] Part time
Occupation: _____ Job title: _____
Does your employer have a matching gift program for charitable donations?
[ ] Yes [ ] No [ ] I don't know

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE AND I AGREE TO NOTIFY THE CENTER IF THERE ARE ANY CHANGES.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

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EMERGENCY MEDICAL TREATMENT CONSENT FORM

Child's Name: _____

In the event that I cannot be reached, I authorize Wonders to transport my child to the nearest hospital emergency room, at the discretion of the emergency team, and I hereby grant my consent for the hospital and its medical staff to provide my child with any emergency medical treatment which a physician deems necessary. If my child is participating in an off campus activity, he or she will be transported to and cared for at the nearest hospital. I agree to accept all financial responsibility for all medical expenses incurred.

CHILD'S BIRTH DATE: _____CHILD'S CURRENT WEIGHT:_____

List all known special conditions or allergies

Describe all past serious illnesses or hospitalizations and their dates

List all medications currently being taken by child

Health Insurance:/ Name of Policy Holder: _____

Insurance company_____

Employer name: _____

ID #: _____Group #: _____

I hereby certify that the information supplied above is, to the best of my knowledge, complete and accurate.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

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DISMISSAL AUTHORIZATION FORM – MARYLAND PROGRAMS

Child Name(s): _____

I, the parent/guardian hereby authorize Wonders Early Learning + Extended Day ("Wonders") to release said Child(ren) from Wonders in accordance with the following:

In addition to Child(ren)' parents and/or guardians, Child(ren) may be released from Wonders to the following person(s) over the age of 16:

Name	Relationship to Student	Phone Number(s)

By signing this authorization form, I hereby understand that this authorization form will remain in effect unless and until a subsequent authorization form is completed, signed, and received by Wonders or a written revocation of this authorization form is received by Wonders, whichever occurs first. I further understand that Wonders reserves the right to request photographic identification for any or all persons who may attempt to pick-up Child(ren) from Wonders and to refuse to release Child(ren) in accordance with either this authorization form, lawful and enforceable court orders, state or federal laws or, in Wonders sole discretion, for the health and safety of the student.

I, on behalf of myself, my spouse, Student's parent(s), and any and all heirs, assigns, agents, personal representatives, insurers, and any other individuals or entities who could act on my behalf or interests, hereby release and forever discharge Wonders, its officers, directors, agents, employees, assigns, representatives, insurers, volunteers, and any other affiliated individuals or entities, from any and all claims, demands, actions and causes of actions and all liability, whatsoever, whether or not negligently caused, in any manner arising out of Wonders' release of Child(ren) in accordance with this authorization form.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

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FAMILY CUSTODY FORM

The following information is requested so we are better able to serve your family's needs. The information provided will be held in the strictest of confidence and will only be viewed by authorized employees. Please be sure the information is complete and accurate and update the center of all new custody developments or changes.

Child's Name: _____

CUSTODY INFORMATION

Are Parents Divorced?	[ ] Yes	[ ] No
Are Parents Separated?	[ ] Yes	[ ] No
Is Custody Currently Being Disputed?	[ ] Yes	[ ] No
Has Custody Been Determined By Court?	[ ] Yes	[ ] No
Is Custody	[ ] Joint	[ ] Sole:
		Custody Granted to: _____

If Joint Custody, please describe day to day details of the arrangements.

Please Describe Any Special Circumstances:

Copies of ALL court orders or agreements concerning Custody must be submitted with this form. If there are restrictions on parent contact, a copy of the court order that outlines the provisions of such a decree must be on file at Wonders Early Learning + Extended Day.

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE AND I AGREE TO NOTIFY THE CENTER IF THERE ARE ANY CHANGES.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

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

Child's Picture

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.**
- **An adult must bring the medication to the facility.**

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 - Specify: _____

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

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

Telephone: _____ FAX: _____

Address: _____

_____

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

This space may 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/We certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ Date: _____

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

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

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

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BABYSITTING RELEASE

I/We, _____, the parents and/or legal guardians of _____, _____, _____(collectively, "the Family") hereby acknowledge and agree as follows:

1. We have read and understand the statement in Wonders' handbook regarding babysitting by Wonders staff.
2. Wonders does not encourage, support or approve the practice of families engaging any Wonders employee or contractor to provide babysitting services, transportation services, or any other service.
3. In the event that the Family does engage any Wonders employee or contractor for any purpose, Wonders does not, in any way, warrant or guarantee the suitability of that employee or contractor for babysitting or any other purpose. Wonders shall not be responsible in any way for any dispute of any nature which may arise between the Family and the employee or contractor, including any and all claims for injury or damage to or loss of property.
4. While engaged by the Family for any purpose, the Wonders employee or contractor is acting outside the scope of his or her employment with Wonders and is an independent contractor of the Family, not a Wonders employee or agent. Any activities or occurrences which occur during such services, including, but not limited to, transportation of children to or from any premises operated by Wonders, are likewise outside the scope of any employment by Wonders. The parents, for themselves and their minor child or children, hereby release Wonders Early Learning + Extended Day and its employees from and hold it harmless and indemnify it against any and all claims arising from the private provision of services.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date