Agape' Early Childhood Learning, Development and Family Life Center

Application Check List 2026-2027

Child's Name: _____

- ☐ Payment Schedule
- ☐ Application for Admission
- ☐ Application for Admission (Infant Addendum #1-4 Only)
- ☐ Emergency Form
- ☐ Record of Immunization
- ☐ Health Inventory (Part 1 – Parents)
- ☐ Health Inventory (Part 2 – Physician)
- ☐ Parent & Center Agreement
- ☐ Pick Up Authorization
- ☐ Authorization for Field Trip Activities and Transportation
- ☐ Photo Release Authorization
- ☐ All About Me

Signature: _____ Date: _____

4318 Rhode Island Avenue Brentwood, Maryland 20722 (301) 927-4674

Agape' Early Childhood Learning, Development and Family Life Center

Application Check List 2026-2027

- [ ] Bright wheel Parent Information
- [ ] Ages and Stages Questionnaire

4318 Rhode Island Avenue Brentwood, Maryland 20722 (301) 927-4674

Agape' Early Childhood Learning, Development and Family Life Center

4318 Rhode Island Avenue * P.O. Box 64
Brentwood, Maryland 20722
(301) 927-4674

2026-2027 School Year

July 20, 2026

Welcome Back!!! We are looking forward to an exciting and fantastic new school year! Due to the sharp increase in costs, we have also had to adjust our prices. Attached is the new application for the 2026–2027 school year.

1. ____ The registration/application fee is **$120.00** per student per year.

2. ____Tuition prices are increasing for this school year. They are as follows:

Infant Care:	$270.00 per student
Non-Potty Trained:	$220.00 per student
Potty Trained:	$210.00 per student
After Care Only:	$115.00 per student

3. ____ The Center **closes at 5:30 pm**. All children should be picked up no later than 5:30 p.m. This allows our staff adequate time to thoroughly clean and sanitize the entire Center in preparation for the next school day.

4. _____We will continue to do everything possible to keep all of us safe (sanitizing and disinfecting the Center). The training that we receive from the Child Care Administration guides us as to how to help keep each person safe.

5. ____ Parents will continue to **CHECK-IN** and **CHECK-OUT** your child at the front door. You must sign your child **IN** for the day and **OUT** in the afternoons. You may leave your child at the front door with our staff for **CHECK-IN** and we can bring your child from their classroom up to you in the afternoons.

6. ____We will check your child **IN** and **OUT** on the Brightwheel app each day. Please make sure you download the app to your phone so that you can communicate with your child's Teachers, and we can communicate with you, if need be, throughout the day.

7. ____Face masks are no longer required at this time for the students ages 2 and over; however, we do have the right to re-enforce masks if the situation warrants it.

8. ____Rules and regulations will change and be rearranged by the Administration to ensure the safety of all. Thank you for your patience as we work through this.

9. ____All payments are made through the Brightwheel app using credit or debit cards.

10. ____All applications **MUST** be filled out on the website (www.agapeearly.com) and submitted to the Center at agapeearly@gmail.com. Please make sure all blank spaces, phone numbers, up-to-date medical records, Parent/Center Agreement, etc. are filled in **before** submitting the application.

11. ____All students in the **Preschool Program (ages 2-5)** are **required** to be in uniform **every day**. Please keep 2 extra sets of clothing for them – underwear, socks, shirt, and pants – in case of accidents.

    GIRLS: Yellow shirt; navy-blue uniform – pants, dress, or skirt
    BOYS: Yellow shirt; navy-blue uniform pants.
    Uniforms can be purchased at "Kids for Less".

12. ____Class books are **required** for the Preschool Program and **MUST** be purchased at time of enrollment.

13. _____ We provide After Care pick-up in the afternoons from Thomas Stone Elementary and Mt. Rainier Elementary School.

14. ____School **begins Monday, August 24, 2026,** at **6:30 am**.

If you have any questions, please feel free to contact us at (301) 927-4674 and leave a clear message. Welcome back and thank you for choosing Agape'!

Bishop Sybil Davis-Williams, Senior Director
Mrs. Sonya Johnson, Director
Mrs. Joflet Selvarajasingham, Associate Director

Agape' Early Childhood Learning, Development and Family Life Center

4318 Rhode Island Avenue * P.O. Box 64
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2026-2027 School Year

FALL TUITION 2026-2027

***Application & Registration Fee:** $120.00 (Every September for the new school year)

Tuition:

Infant Care:	$270.00 per week (Ages 6 weeks to 23 months)
Non-Potty Trained	$220.00 per week (Ages 2 years old)
Potty Trained	$210.00 per week
After Care:	$115.00 per week *(includes transportation from Mt. Rainier and Thomas Stone Elementary Schools to Center)*

Book Fees:

Each student works out of his/her own books for the whole school year. The sheets are worked on and sent home for parents to review.

Bumble Bees:	(2/3 year olds)	$ 65.00 (3 books)
Dolphins:	(3/4 year olds)	$ 90.00 (4 books)
Eagles:	(4/5 year olds)	$165.00 (8 books)

SCHOOL SUPPLIES FOR FALL 2026-2027:

Please pick up the following school supplies for your child and label each supply with your child's name and don't forget to bring an extra change of clothing.

- ★ 5 yellow – uniform shirts
- ★ 3 navy blue – uniform pants (boys or girls)
- ★ 3 navy blue – uniform skirts (girls)
- ★ Backpack
- ★ Pencil Box (with your child's name on it)
- ★ Pocket Portfolio Folders (2)
- ★ Glue
- ★ Crayons (large)
- ★ Scissors (children's)
- ★ Crayola Washable Markers
- ★ Two extra sets of clothing (2) - shirt, pants, socks, underwear, t-shirts (LABELED with Child's Name)
- ★ Kleenex tissue (4 boxes) - to be shared by class
- ★ Baby wipes (4 packs) - to be shared by class
- ★ Antibacterial Hand Soap (4) - to be shared by class
- ★ Paper Towels (4 packs) - to be shared by class

Thank you for your support. We welcome your fund-raiser ideas and tax-deductible monetary donations to help with the support of our Center. If you work at a company that is interested in sponsoring our Child Care Center, please contact the office at (301) 927-4674. Thank you for your cooperation in these matters.

Agape' Early Childhood Learning, Development and Family Life Center

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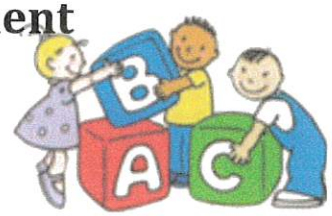

APPLICATION FOR ADMISSION
2026-2027
(Please print)

Application Date:_____ Date to Begin:_____

CHILD'S NAME:_____ **Date of Birth**:_____
Name used at home:_____ Present Age:____ Sex:_____

Address:_____
_____

Telephone Number: (home)_____ (cell)_____

Email Address:_____

FAMILY INFORMATION

Father:_____ Mother:_____
SSN#:_____ SSN#:_____
Occupation:_____ Occupation:_____
Business Address:_____ Business Address::_____
_____ _____
Phone No.:_____ Phone No.:_____

Is child adopted?_____ If yes, at what age?_____
Stepparent?_____ Which?_____
Death of one parent?___ Which?_____
Divorced?_____ Which?_____
Names and ages of other children:_____
Other persons living in the home?_____

Previous programs and/or day care centers attended & telephone numbers:
_____ ( ) _____
_____ ( ) _____

Reason for leaving:_____
Religious affiliation:_____

SOCIAL & PHYSICAL GROWTH - Is your child.....

Right handed?_____	Left handed?_____	Well Coordinated?_____	Clumsy?_____
Good with hands?_____	Impulsive?_____	Shy?_____	Excitable?_____
Restless?_____	Happy?_____	Domineering?_____	Handicapped?___
Hypertensive?_____	On medication?_____	If yes to medication, what type?_____	

Over

Does your child....

Have falling spells?_____ Exhibit daredevil behavior?_____ Have unusual fears?___
Talk well?_____ Have a good attitude about him/herself?_____
Get along well with other children?___

Does your child have special needs?_____
If yes, are you willing to share a copy of their IEP/IFSP?_____

Are there any other characteristics that your child exhibits that we should know about? Please explain.

_____
_____

Any food allergies?_____
_____
_____
_____

Child's T-shirt size:_____

**** All students should be picked up by 5:30 pm, so that staff can spray and disinfect the whole Center for the next day.***

****

Office Use Only

Start Date: _____
Child's Class: _____
Orientation Date: _____

Registration Paid $_____ Date Paid _____
Book Fees: $_____ Date Paid_____

Books Received Date: _____ (staff initials)
T-shirt Received Date: _____ (staff initials)
Yearbook Received Date: _____ (staff initials)

Agape' Early Childhood Learning, Develo
and Family Life Center
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APPLICATION FOR ADMISSION

(Infant Addendum #1-4 ONLY)

(Please print)

CHILD'S NAME:_____ **DATE OF BIRTH:**_____

1. What are you currently feeding your child? Infant Formula_____ Breast Milk_____ Other _____

2. How often a day does your child eat? _____ **times per day**

3. **SOCIAL & PHYSICAL GROWTH**
   Does your child sleep in the room alone? ____
   Does your child sleep in a crib?_____

4. **DEVELOPMENT HISTORY OF CHILD**
   Age at which child: Crept on hands & knees _____ Sat up alone____ Walked alone_____
   Begin to name simple objects_____ Repeat short sentences_____
   Slept through the night_____ Began toilet training_____

5. Word child uses for: Urination_____ Bowel Movements_____ Usual time for BM_____

6. Does child dress self?_____ Undress self?_____

7. What time does your child usually eat: Breakfast_____ Lunch_____ Snack_____

8. Is your family vegetarian?_____ Other dietary restrictions_____

9. **HEALTH HISTORY OF CHILD:**
   What past illness has he/she had?_____ At what age?
   Chicken Pox_____ Measles _____ Mumps_____ Diabetes_____ Scarlet Fever____
   Other_____

10. Does your child have frequent colds and/or ear infections? If yes, please explain_____
    _____

11. Any allergies?_____ If yes, how does it usually manifest itself?_____

12. Asthma_____ Hay Fever_____ Hives_____ Other_____

13. Who has cared for the child other than his/her parents?_____

14. Has your child had experiences in playing with other children? _____ Church____ Day Care_____

15. By nature is your child... Friendly_____Withdrawn_____ Aggressive_____ Shy_____

16. What makes your child upset?_____

17. How does your child show his/her feelings?_____

18. What do you find is the best way of handling your child?_____

19. Who does most of the disciplining?_____

20. How do you comfort your child?_____

21. Is your child frightened by any of the following: Animals___ Dark___ Loud Noises___ Storms____

22. Are there any other characteristics that your child exhibit that we should know about? Please explain.

_____

_____

COMMENTS: (In what particular way can we help your child?)

_____

_____

_____

Agape' Early Childhood Learning, Development and Family Life Center

4318 Rhode Island Avenue
Brentwood, Maryland 20722
(301) 927-4674

PARENT & CENTER AGREEMENT

Agape' Early Childhood, Learning Development Center aims to enrich the life of each child by encouraging and planning for the mental, social, emotional, physical, and spiritual development involved in the care of:

Child's Name: _____

The following terms are understood and agreed between **Agape' Early Childhood, Learning Development Center** and (Parent or Guardian):

Parent/Guardian's Name:_____

THE CENTER AGREES:

We are CLOSED Saturday, Sunday and the following holidays and "in service" training days.

*New Year's Eve	Memorial Day	Veteran's Day
New Year's Day	Juneteenth (June 19)	Thanksgiving Day
Martin Luther King, Jr. Birthday	Independence Day	Day After Thanksgiving
President's Day	Labor Day	** Christmas Break (2 weeks)

_____ 1. **IMPORTANT NOTE:** The *Center will be **CLOSED** on the following Monday if a holiday falls on the weekend (Saturday or Sunday).

_____ 2. The Center will be **CLOSED for two (2) weeks** for ****Christmas Break** from **Monday, December 21, 2026 to January 4, 2027**. Parents will **NOT** be charged for the **Christmas Break.**

_____ 3. **Refunds are not given for Center holidays, in-service training or days the child is absent.**

THE CENTER WILL:

1. Give written notice in the event of any exposure to a contagious disease with the group.
2. Administer prescription medications to children under the Child Care Administration regulations. (See the "Medication Form" in the Child's enrollment packet.
3. Exercise reasonable care and judgment in all matters related to the welfare and safety of the child.
4. In case of an accident or illness, the teacher or assistant will take prompt and reasonable

measure in the best interest of the child and will notify the parent/guardians as soon as possible.

5. Provide breakfast, lunch and afternoon snack.

6. Provide educational activities to develop and enhance physical, emotional, social, mental, and moral development.

7. Provide resources in sufficient quantity to allow for a variety of play and learning activities during the day.

8. Our Center follows a policy of non-discrimination. No person is excluded from school attendance or employment because of race, color, or national origin.

9. We accept children with special needs and will make reasonable efforts to accommodate them to the best of our ability. Our Center does allow therapists to come and to work with the children.

10. **WILL NOT** release the child to anyone other than the parent or guardian unless written permission is received from the parent or guardian.

THE Parent/Guardian(s) AGREE:

____ 1. Tuition is due on **Monday of each week** that the child is enrolled in the program. Because the child holds a slot in the program, tuition is still due whether the child is present or absent; including snow and inclement weather days.

____ 2. Voucher co-payments are due on **Monday of each week**.

____ 3. The parent/guardian(s) will pay a **non-refundable application & registration fee of $120.00** and the first week's tuition to enroll and secure a position for his/her child.

____ 4. $_____ will be paid every Monday.

____ 5. If the tuition is **NOT paid by Tuesday 5:30 pm** (for the week your child is enrolled), then your child will not be allowed to enter the Center until the tuition and late payment fee ($10.00 per day until Friday) are paid in full for that week.

____ 6. An activity fee may be charged from time to time depending on the types of trips taken during the school year.

____ 7. A book fee of $_____ for books for the school year.

____ 8. **The Center will close at 5:30 p.m. This gives us time to thoroughly clean and sanitize the Center in preparation for the next school day.** If your child remains after 5:30 pm, a **late pick-up fee of $2.00 per minute per child** will be charged. When a child remains after 5:30 p.m., the individual picking up the child will be asked to sign a form stating the time. **The parent/guardian will be responsible for payment of any late pick-up fees. Late pick-up fee is due the next day before the child enters the Center.**

____ 9. In case of default of fees, collection fees and/or legal fees will be added and is the parent/guardian(s) responsibility.

____ 10. The parent/guardian will **provide the required forms** from the enrollment packet **before** the child can begin **attending the Center**.

____ 11. **Sick care is NOT available**. It is a parent/guardian's responsibility to make other arrangements when a child is ill. A teacher will observe the children daily for symptoms of contagious diseases or illnesses before they are admitted for the day. If a child has a fever, that child will not be re-admitted until free of fever for 24 hours.

____ 12. In the event that a child has a contagious illness, the parent/guardian will notify the Center. The child will not be allowed to return until the contagious period is past.

____ 13. In the event of an emergency, the Center has permission to take reasonable measures necessary for the welfare and safety of the child as determined by the judgment of the teacher or director

____ 14. Parent/guardians are required to participate in two conferences with your child's Teacher during the year. This allows us to provide an update on the child's developmental progress. Parents will be notified by the Teacher thru Brightwheel and assigned a time.

____ 15. Each child is given a 30-day probationary period to allow them to adjust to the Center and for the Center to adjust to them.

____ 16. The Center reserves the privilege of dismissing any child if, after enrolling, he/she is unable to participate in group experiences and the daily program.

____ 17. It is the parent/guardian's responsibility to make sure that your child always has 2 extra sets of clothing – including underwear - at the Center (labeled with your child's name).

____ 18. **UNIFORMS** are **REQUIRED** by our Center to be worn by **all** preschool students (during the school year) unless otherwise stated. Students not in compliance may be dismissed from the Center.

____ 19. Parent/guardians are legally liable for their child's destructive or unlawful actions while at the Center.

____ 20. Because of the seriousness of body fluids and the safety of children and staff, I understand **that any child who bites others can and will be dismissed** from the Center at the discretion of the Directors.

____ 21. Agape's Full Day Program begins at **9:00 am.** Any child arriving **AFTER 9:15 am will NOT be admitted**, except in cases of scheduled doctor appointments. In cases of scheduled doctor appointments, the ***doctor's note is required for admittance***.

____ 22. **It is the parent(s)/guardian's responsibility to make sure that the Center always has a current telephone number and contact information on file so that they can be reached in cases of emergency.**

____ 23. If your child is exhibiting signs of unwellness (sick) when they come to the Center, we will not accept them. We will send them back home with you. They will **NOT** be allowed to enter the Center. We want to keep everyone safe and protected.

____ 24. We will check your child **INTO** and **OUT OF** the Center on Brightwheel each day. Please make sure you download the app to your phone.

____ 25. Handwashing and hand sanitizing are **required** when entering the building and throughout the day.

____ 26. Rules and regulations are subject to change and will be rearranged by Administration to ensure the safety of all. Thank you for your patience as we work through this.

____ 27. All payments will be made through Brightwheel via credit or debit card.

I (We) understand and agree to abide by the policies and procedures as stated in the Parent-Student Handbook and this Parent/Center Agreement. I (We) also understand that from time to time the Center's Director may implement or change policies as needed. I understand that I will be notified of such changes.

I also understand that I can go to **http://earlychildhood/marylandpublicschools.org/parentbrochureguide** to download a copy of the Early Childhood Guide to Regulated Child Care.

_____ _____

Parent(s) Signature Date

_____

Parent (PRINT NAME)

_____ _____

Director/Office Manager Date

Revised 07-20-2026

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PICK-UP AUTHORIZATION
2026-2027

Parents, please indicate on this list the names of **all** persons who you authorize to pick-up your child from **Agape' Early Childhood Learning, Development and Family Life Center**. Inform these people that identification might be required when they do come to pick-up your child. Most importantly, please **REMEMBER TO *UPDATE*** this list from time to time as necessary to keep it current.

CHILD'S NAME:_____

Below are the names of persons I authorize to pick-up my child, _____.

_____ _____
Parent(s)/Guardian's Signature Date

_____
Print Name

	AUTHORIZED NAMES	TELEPHONE #	Relationship to Child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Agape' Early Childhood Learning, Development and Family Life Center

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AUTHORIZATION FOR FIELD TRIP ACTIVITIES AND TRANSPORTATION

August 2026 - August 2027

I, _____, hereby give Agape' Early Childhood Learning,

Development and Family Life Center and its authorized representatives, permission to transport my child,

_____, on any field trips outside the Center by vans and

authorized vehicles, as long as:

1) I am notified at least 24 hours in advance of the field trip, and
2) I am given information regarding the time and location of the field trip activity

I do understand and acknowledge that Agape' Early Childhood Learning, Development and Family Life Center will NOT be held responsible in case of injury during the field trip activity and transportation.

_____
Parent(s)/Guardian Signature

_____
Print Parent Name

_____
Date

Revised 2024-2025

Agape' Early Childhood Learning, Development and Family Life Center

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AUTHORIZATION TO USE PHOTOGRAPHS
RELEASE FORM

I, _____, hereby give Agape' Early Childhood Learning, Development and Family Life Center permission to use my/or my child(ren)'s, _____, photos for advertising and marketing (website, flyers, posters, etc.) purposes.

***Please note:** These pictures will **NOT** be sold by Agape' to any other companies.*

Signed by: X_____ Title_____
Authorized Signature

X_____
Printed Name of Above Signature

Date: X_____

* *

For Office Use ONLY:

Release received by:_____

Date:_____

2026-2027

A Great Atmosphere and Place to Educate

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:☐ No:☐

Meals your child will receive while in care:

BK☐ LN☐ SU☐ AM Snk☐ PM Snk☐ Evng Snk☐

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(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	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

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 _____

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete.*

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 IMMUNIZATION CERTIFICATE

Maryland
DEPARTMENT OF HEALTH

STUDENT/SELF NAME: _____

LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1														
2														
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr		
4														
5														

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local/state health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

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 MDH 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 MDH COMAR 10.06.04.03 are available at www.health.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.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes○ No○ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes○ No○ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes○ No○ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes○ No○ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes○ No○ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes○ No○ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes○ No○ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations**. The immunization certification form (MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at:https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: https://health.maryland.gov/Pages/Home.aspx#

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program

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:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

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.

_____ _____
Printed Name and Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Health Care Provider

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

2. Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

3. 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:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. 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).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. Should there be any restriction of physical activity in child care?
☐ No ☐ Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)

10. **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care 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.

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

ALL ABOUT: _____
Child's First Name or Nickname

Child's Name: _____ Birthdate: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone _____

Address: _____ Zip Code: _____

Provider/Center: Agape' Early Childhood Learning, Development and Family Life Center Phone: (301) 927-4674

Address: 4318 Rhode Island Avenue Brentwood, Maryland 20722

The information contained herein is for CONFIDENTIAL USE ONLY

THINGS MY CHILD DOES WELL
WHAT MY CHILID LIKES AND DISLIKES
THINGS I AM WORKING ON WITH MY CHILD
MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES
MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES
THINGS MY CHILD MIGHT NEED HELP WITH
WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME? (For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.

Signatures:

Parent/Guardian: _____ Date: _____

Provider: _____ Date: _____

Updates:

Parent/Guardian: _____ Date _____ Parent/Guardian: _____ Date: _____

Provider: _____ Provider: _____