Content of Enrollment Packet

~ PARENT HANDBOOK VERIFICATION. Please sign off that you have read the parent handbook that is available online at mmchildrenscenter.org

~BOARD INTEREST. If you would like to be considered to serve on the Board of Directors please complete the form and return by July 1.

~ALLERGY & ASTHMA INFOMRATION SHEET. To be completed by all parents whether or not your child has an allergy/asthma.

~MEDICAL RELEASE & PHOTOGRAPH PERMISSION. Please read and sign both statements.

~EMERGENCY FORM. This gives us information we need to contact in case of emergency during school hours. This is also available on the school's website.

~HEALTH INVENTORY. These forms will need to be completed by a doctor. New students only.

~ALL ABOUT ME. This form tells us all about your child and is useful for your teacher.

~FIELD TRIP. This must be signed by everyone.

~CHILD PROTECTION QUESTIONNAIRE. It is now required for all volunteers at MMCC to complete this form. They are reviewed by the Director and filed separately from other student records. This is filled out each year your child attends. If you have any questions, please contact the director.

~ABESTOS FORM. Please read and sign.

~SCHOOL CALENDAR

PLEASE RETURN ALL FORMS TO THE OFFICE VIA EMAIL OR DROP OFF BY JULY 1.
THANK YOU~

Montgomery Methodist Children's Center

Parent Handbook Receipt Verification

I ____ have received and read the MMCC Parent Handbook. I understand that if I have any questions about the policies or procedures discussed in the handbook that I may discuss them with the Director.

Signature ____________________________ Date ______________________

The Board of Directors

Below is a copy of the expression of interest to be a member of the Children's Center's Board of Directors. The Board of Directors is responsible for setting the policies of the Children's Center, for serving as a liaison between the Center and the Church, and for reviewing issues that arise throughout the school year. It also serves as a family liaison and approves the budget, tuition rates, salaries, and fundraisers.

The membership of the Board includes the Chairperson, the Director of the Center, staff representative(s), two or more parent representatives, and the Office Manager.

As a parent, you can serve your school as a Board member. Please think about volunteering your time and efforts.

EXPRESSION OF INTEREST

To: Chairman, Board of Directors
Montgomery Methodist Children's Center

I am interested in serving as a member of the Board of Directors for the Children's Center through August 2025.

Name____

Date____

Phone Number_______________________________________

My Child is in the_________________________________class.

(If interested, please return completed form to the Pre-school office by July 1, 2024.)

Montgomery Methodist Children's Center

Student Allergy and/or Asthma Information Sheet

This form is required by MMCC even if you child has no known allergies or asthma. If any changes take place in your child's medical status during the school year please notify the school office. Thank you for your cooperation!

Child's name ______________________________ Date of birth: ____________________

____ Please initial if your child has no known allergies or asthma. If not, please sign & date this form below.

If your child has food or other allergies/asthma please indicate below:

Food Allergies: (Please be specific) ____

EPI-PEN: Required? Yes ___________ No ___________

*If your child's allergy requires treatment (such as an Epi Pen, antihistamine, or other medication) please complete an **Allergy & Anaphylaxis Emergency Care Plan**. A doctor's signature is required on this form.

Signed: ________________________________ Date: _____________________________

Montgomery Methodist Children's Center

Child's Full Name____

Permissions 2024-2025

Medical Release

I authorize and hereby grant permission to MMCC & staff to administer to my child/children any and all medical/dental attention in the event of an illness or injury. This is in event of an injury or illness until such time I can be contacted. I further authorize MMCC & staff, as well as the above stated emergency contact, to consent to medical, surgical or dental examination and/or treatment. This permission includes, but is not limited to the administration of first aid, the use of an ambulance, and any other medical/dental procedures under the recommendation of qualified medical personnel.

I further acknowledge & understand that I will be responsible for any and all medical/dental related bills that may be incurred on behalf of my child/children while they are on the premises of MMCC.

I have read the above medical wavier & fully understand that by signing this form I agree to the terms listed above.

Signature: ________________________________ Date: ______________________

Photo Permission

During the school year, MMCC may photograph or video your child for educational or informational purposes. Your child will not be identified by name. If you do not wish to have your child appear in a video or photograph (for the school's website or brochure) please sign below. This does not include pictures taken by MMCC staff for them to use for a class event, birthday or weekly emails.

Circle below and sign.

I DO NOT want my child photographed.

It is OK to photograph my child.

Signature: ________________________________ Date: ________________________

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.*

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

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

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

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: ______________________ Last / First / Middle **Birth date:** ________ Mo / Day / Yr **Sex** M☐ F☐

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: Address: Phone:	Name: Address: Phone:	Name: Address: Phone:	☐ Yes ☐ No **Child Care Scholarship** ☐ Yes ☐ No	Physical Exam: Dental Care: 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:

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ______/______/______

COUNTY ____________________ SCHOOL ____________________ GRADE ______

PARENT OR GUARDIAN NAME ____________________ PHONE NO. ____________________

ADDRESS ____________________ CITY ____________________ ZIP ______

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	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 as indicated.

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

2. ____
Signature Title Date

3. ____
Signature Title Date

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

Clinic / Office Name
Office Address/ Phone Number

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
	Select a test type.		
	Select a test type.		
	Select a test type.		

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

Environmental Health Bureau
mdh.envhealth@maryland.gov

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

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

ALL ABOUT: ______________________________

Child's First Name or Nickname

Child's Name: ______________________________ Birthdate: ______________

Parent/Guardian: ______________ Home Phone: ______________ Work Phone: ______________

Address: ______________________________ Zip Code: ______________

Provider/Center: ______________________________ Phone: ______________

Address: ______________________________ Zip Code: ______________

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL
WHAT MY CHILD 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: ____________

FIELD TRIP PERMISSION SLIP
2024-2025

I give my permission for my child____________________
to go on field trips which are planned and carried out by the Montgomery Methodist Children's Center during the 2024-2025 school year. **I understand that myself or somebody appointed by me, will transport my child.** My child will be riding in a car provided with a seat belt. My child will be in a safety seat and that safety seat will not be placed in the front passenger seat. I will not hold the school liable in case of accident or injury.

I understand that field trips will be announced in the monthly newsletters.

______________________ ______________

signature date

Laity Sexual Misconduct Questionnaire

Baltimore-Washington Conference – Church Conference **2022**

To be completed and signed by all persons who are to work with children and youth within the ministry of this congregation. Please check the appropriate box. If more space is needed, please use an additional piece of paper

Name:	
Date :	

☐ YES ☐ NO	1. Have you ever filled out this questionnaire for this church or agency? • If NO (or unsure) please answer questions 3 - 9 below. Then sign and return this form. • If YES, please give the date: _____ and answer question #2
☐ YES ☐ NO ☐ NOT SURE	2. If you answered "YES" to Question #1, have any answers changed since you filled out that copy? • If NO, please sign and return this form. • If YES OR NOT SURE, please answer questions 3 - 9 below
☐ YES ☐ NO	3. Have you ever been accused, in a written and signed statement of sexual misconduct with a child or a youth?
☐ YES ☐ NO	4. Have you ever been accused in a written and signed statement of sexual misconduct with an adult?
☐ YES ☐ NO	5. Have you ever been dismissed from any position, volunteer or salaried, because of accusations of sexual misconduct on your part?
☐ YES ☐ NO	6. Have you ever resigned from any position, volunteer or salaried, because of an accusation of sexual misconduct on your part, or to avoid being dismissed because of an accusation of sexual misconduct on your part?
	If your response to any of the foregoing questions (2 through 5) is "yes", please provide all details regarding each accusation of sexual misconduct that has been made with respect to you, including a description of the alleged conduct, the name of the person who made the accusation, the date of the alleged misconduct, and the name of your employer at the time of the alleged misconduct. Please attach explanation.
☐ YES ☐ NO	7.a Have accusations of sexual misconduct on your part ever resulted in civil or criminal court proceedings at any level (e.g. indictment, arrest, trial, etc.)? If yes, please provide the complete details of those proceedings (including dates, circumstances, the jurisdiction where the proceedings occurred, the nature of the accusations, and the result of the proceedings). Provide explanation below or attach additional document.
☐ YES ☐ NO	7.b Have accusations of sexual misconduct against you resulted in civil or criminal court proceeding on more than one occasion? If so, please provide the same details with respect to each such proceeding. Please attach explanation.
☐ YES ☐ NO	8 Other than the above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people? Please attach explanation.

COMPLETED FORM TO BE KEPT ON FILE AT THE <u>LOCAL CHURCH</u> – DO <u>NOT</u> SUBMIT TO CONFERENCE.

MEMORANDUM

SEPTEMBER, 2024

TO: PARENTS
FROM: MONTGOMERY METHODIST CHILDREN'S CENTER
MMCC Board of Directors
RE: Availability of Asbestos Management Plan

In October 1986, the U.S. Congress enacted the Asbestos Hazard Emergency Response Act (AHERA). Under this law, comprehensive regulations were developed to address asbestos problems in public and private elementary schools. These regulations require most schools to inspect for friable and non-friable asbestos, develop asbestos management plans that address asbestos hazards in school buildings and implement response actions in a timely manner.

These regulations assign schools many new responsibilities. Our program for fulfilling these responsibilities is outlined in our asbestos management plan. This plan contains information on our inspections, re-inspections, response actions and post-response action activities, including periodic surveillance activities that are planned or are in progress.

You can review this plan during normal school hours in the Pre-school Office.

If you have any questions about reviewing our management plan please contact Kate Martin at 301-253-4884.

Inspections were conducted in each classroom in November 1991, November 1994, November 1997, November 2000, November 2003, November 2006, November 2009, November 2012, September 2015, November 2018, and November 2021. Our next scheduled inspection is in November 2024.

Signature: ______________________________

Date: ______________________________

MMCC 2024-25 Calendar

September

Mon. Sept. 2	Labor Day - SCHOOL AND OFFICE CLOSED
Tues. Sept. 3	Visitation Day and Back to School Meeting with teacher for M - TH Pre-K 4's ** **(with parents, No siblings)**
Tues. Sept. 3	Visitation Day for T/TH 2's and 3's; teacher will schedule time **(with parents, No siblings)**
Wed. Sept. 4	Visitation Day for MWF 3's; teacher will schedule time **(with parents, No siblings)**
Wed. Sept. 4	Visitation Day for MW 2's (with parents, No siblings)
Wed. Sept. 4	Visitation Day for MWF Pre-K 4's and Back to School Meeting with teacher** **(with parents, No siblings)**
Wed. Sept. 4	First full day M-TH Pre-K 4's
Thurs. Sept. 5	T/TH 2's and T/TH 3's come for one hour (Teacher schedules time)
Fri. Sept. 6	MWF 3's come for one hour 9:00-10:00 or 11:00-12:00 teacher will schedule which time
Fri. Sept. 6	Visitation Day for Friday 2's; teacher will schedule time **(with parents, No siblings)**
Fri. Sept. 6	First full day for MWF Pre-K 4's
Fri. Sept. 6	MW 2's come for one hour (9:00-10:00)
Mon. Sept. 9	First full day MWF 3's
Mon. Sept. 9	M/W 2's come for two hours (9:00-11:00)
Tues. Sept. 10	T/TH 2's come for two hours (9:00-11:00)
Tues. Sept .10	First full day for T/TH 3's
Wed. Sept. 11	M/W 2's first full day 9:00-12:00
Thurs. Sept. 12	T/TH 2's first full day 9:00-12:00
Fri. Sept. 13	Friday 2's come for one hour (9:15-10:15)
Wed. Sept. 18	**ALL CLASSES DISMISS AT NOON -** Staff Meeting
Fri. Sept. 20	First full day for Friday 2's 9:15-11:45

October

Mon. Oct. 14	Individual Picture Day: MW 2's; MWF 3's; MWF Pre-K 4's
Tues. Oct. 15	Individual Picture Day: T/TH 2's and 3's; M-TH Pre-K 4's
Fri. Oct. 18	Individual Picture Day:- Friday 2's & Make-up Day
Mon. Oct. 21	Gaver Farm Field Trip (MW, MWF classes) **TBD**
Tues. Oct. 22	Gaver Farm Field Trip (T/TH; M-TH classes) **TBD**
Mon. Oct. 28	**NO SCHOOL - Staff In-Service Day**

November

Fri. Nov. 1	Parent Conferences for MWF 3's MWF 4's & Friday 2's- No class for these students
Mon. Nov. 4	Parent Conferences for MW 2's, M-Th 4's- No class for these students
Tues. Nov. 5	Parent Conferences for T/TH 2's & T/TH 3's- No class for students
Tues. Nov. 26	**ALL CLASSES DISMISS AT NOON - Staff Meeting**
Nov 27, 28, 29	Thanksgiving Holiday - School and Office Closed

December

Mon. Dec. 2	Christmas Shop - (M/W, MWF classes)
Tues. Dec. 3	Christmas Shop - (T/Th class; M-TH classes)
Wed. Dec. 18	Christmas Program MW, MWF classes
Thurs. Dec. 19	Christmas Program - (T/TH and M-TH classes)
Fri. Dec. 20	Christmas Program for Friday 2's (in the classroom) at 9:15am
Fri. Dec. 20	**NO SCHOOL - Staff In-Service Day**
Dec 23 - Dec 31	Christmas Holiday - School and Office Closed

****ON VISITATION DAY PRE-K 4's PARENTS WILL SPEND 30 MINUTES WITH THEIR CHILD IN THE CLASSROOM, THEN 30 MINUTE BACK TO SCHOOL MEETING WITH THE TEACHER.****

MMCC 2024-25 Calendar

January

Wed. Jan. 1	New Years Holiday - School and Office Closed
Thurs. Jan. 2	Classes resume
Fri. Jan. 17	**NO SCHOOL- Staff In-Service Day**
Fri. Jan. 17	Registration Day for returning students & siblings
Mon. Jan. 20	**Martin Luther King, Jr. Day - School and Office Closed**
Tues. Jan 21	Registration for MUMC members
Wed. Jan. 22	Registration for MMCC alumni
Thurs. Jan. 23	Registration Open to the Public

February

Mon. Feb. 17	**Presidents' Day - School and Office Closed**
Tues. Feb. 18	**ALL CLASSES DISMISS AT NOON**- Staff Meeting

March

Mon. Mar. 10	Class Pictures (MW 2's, MWF 3's)
Tues. Mar. 11	Class Pictures (T/Th 2's & 3's, M-TH 4's)
Fri. Mar. 14	Class Pictures (Fri. 2's & MWF 4's)
Wed. Mar. 26	**ALL CLASSES DISMISS AT NOON-** Staff Meeting

April

Tues. Apr. 15	**NO SCHOOL- Staff In-Service Day**
Apr. 16-April 21	**Easter/Spring Break- School and Office Closed**

May

Thurs. May 8	**NO SCHOOL - Staff In-Service Day**
Wed. May 14	Optional Parent Confereces for MW 2's
Thurs. May 15	Optional Parent Conferences for T/TH 2's & 3's; and M-TH classes
Fri. May 16	Optional Parent Conferences for MWF 3's & 4's, Fri. 2's
Fri. May 23	Last Day of School for Fri. 2's
Mon., May 26	**Memorial Day - School and Office Closed**
Tues., May 27	Last Day of School for T/TH classes
Wed., May 28	Last Day of School for MW 2's, MWF & M-TH Classes (Moving On Ceremony for all 4's classes)

***This calendar is subject to change.**