Raising Kings & Raising Queens
Before & Aftercare Program

Location:
RK - 13604 Annapolis Road
RQ -15222 Old Chapel Road
Bowie, MD 20720

Hours of Operation:
Monday-Friday
6am-8:30am & 2pm-6:30pm

For More Information:
Director – Rev. McBride
newlifembowie@gmail.com
(301) 806-0188

Welcome to Raising Kings & Queens Before & Aftercare Program!

Raising Kings
Raising Kings Before/Afterschool Program for Boys 4th-7th Grades
Encouraging, Empowering and Engaging Young Boys!
Program Details:
*Only $150 per week
*Includes After-school Transportation (Bowie Area)
*Space is limited to 30 students
*Mentorship for BOYS for the 2019-20 school year
*Homework Assistance
*10-month Life Skills Training
*Etiquette Training
*Weekend Field Trips
*Dinner every Tuesday/Thursday
*Guest Motivational Speakers
*Fun & Engaging Activities
*Character/Self Confidence Building

Raising Queens
Raising Queens with Confidence, Character, and Civility.
To develop young women into queens of confidence, character and civility.

Program Description:
A 10-month personal development after-school program for girls ages 9-13 to support the maturation of life skills in the areas of Self-Image & Wellness, Character Education and Home Economics.

The all-inclusive program provides a project-based learning experience that includes: Lecture, interactivity and group learning; offsite activities; guest speakers; and community service. The goal of the program is to nurture young women through the physical, emotional and social adolescent stages of life by providing a safe learning environment to support critical thinking, self-exploration and community building.

We are always open to suggestions and feel communication is an essential part of this ministry. Thank you for the opportunity to serve your family through this ministry!

Raising Kings & Raising Queens
newlifembowie@gmail.com
(301) 806-0188

BEFORE & AFTERCARE ENROLLMENT REGISTRATION

CHILD INFORMATION

Name of Child (Last, First, Middle Int.): _____

Nickname: _____ Age: _____ Sex: _____ DOB: _____

Name of Child#2 (Last, First, Middle Int.): _____

Nickname: _____ Age: _____ Sex: _____ DOB: _____

Name of Child#3 (Last, First, Middle Int.): _____

Nickname: _____ Age: _____ Sex: _____ DOB: _____

Name of Child#4 (Last, First, Middle Int.): _____

Nickname: _____ Age: _____ Sex: _____ DOB: _____

Child's Primary Language: _____ Parent/Guardian's Primary Language: _____

Home Email Address: _____

Home Phone: _____

Child's Home Address: _____

Parent/Guardian Marital Status: Single Married Divorced Widowed

Primary Residence: Mother Father Both Guardian: _____

List the family members your child lives with-include names and ages of siblings: _____

_____

_____

BEFORE/AFTERCARE ATTENDANCE

Please circle the days in which your child will be attending the program.

BEFORE -- Mon Tues Wed Thurs Fri Arrival Time: _____ School Start Time: _____

AFTERCARE – Mon Tues Wed Thurs Fri School End Time: _____ Departure Time: _____

School Name: _____

Address: _____

Phone: _____

WILL YOUR CHILD NEED TO BE PICKED UP FROM SCHOOL? YES NO

If yes, what is the best time to pick them up? _____

PRIMARY CONTACT & RELEASE FORMS

Parent/Guardian #1: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

Parent/Guardian #1: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

EMERGENCY CONTACT AND RELEASE PERSONS

Please notify the center if an Emergency Release Person will pick up your child on a given day. For the safety of your child, we will request all authorized release persons to provide Government-issued photo identification at the time of pick-up. All persons below must be 18 or older, unless he/she is the parent of the child.

Name #1: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

Name #2: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ Home Email Address: _____

Driver's License Number / State: _____

Work Phone/Extension: _____ Work Hours: _____

The persons designated in this section will be contacted and are authorized to pick up my child if there is a medical or other emergency and I cannot be reached. Parent/Guardian must complete any state-specific emergency release form required by individual state child care licensing regulations.

- The Before/Aftercare staff will release your child only to you or to those persons you have listed above. Emergencies may prevent you from picking up your child; therefore, include those individuals whom you would authorize in such events. If you want a person who is not identified above to pick up your child, you must notify school staff in advance in writing. Your child will not be released without prior authorization. In the event you call a pick-up authorization into the school because you are unable to submit your authorization in writing, we will use your personal information to verify your identity. Please notify emergency contacts that a government-issued photo ID must be presented to our staff.

- If you must pick up your child after closing time, you will be charged a late fee per every 15 minutes or portion of 15-minute period, per child, until the child is picked up. Per state licensing regulations, we may be required to contact local authorities after a certain amount of time. Please contact the Director for additional information.

Please initial each section listed below, then sign and date the last.

TUITION AND FEES

_____ **REGISTRATION FEE:** I understand that an annual, non-refundable, registration fee of $**150** shall be paid in advance to enroll my child.

_____ **SECURITY DEPOSIT:** I understand that an annual, non-refundable, security deposit fee of $ **0** shall be paid in advance to enroll my child. The security deposit will be used towards the last week of care due to early termination or the last week of school.

_____ **TUITION & MODIFICATIONS:** $**150** per week is the current tuition rate for the program I have chosen. I understand that the rates are subject to change with reasonable notice as conditions require.

_____ **PAYMENT OF TUITION: All fees are due in advance and are collected on Monday on a weekly, biweekly, on a monthly basis.** You may choose which ever payment method is convenient for you. (i.e., a monthly payment would cover the entire month in advance and a biweekly payment would cover 2 full weeks in advance).

If the program is closed on Monday, then all tuition payments must be paid on previous Friday before closing to avoid late fees.

Please note that you will be charged according to the number of Friday's in that particular month. This is important especially for those months that have 5 Monday's and you are paying monthly instead of weekly.

We accept cash, check, money orders, and you can also pay online at www.newlifebowie.com a $5.00 surcharge will be added with all online payments.

When you bring your child in on Monday, please place your child's payment in a sealed envelope. Write your name, child's name, the payment amount, and the date on the front of the envelope. All payments must be given directly to the Director or placed in the payment mailbox located in the Youth Center.

Please do not place tuition payments under the door. New Life Bowie Ministries will not be responsible for misplaced or lost payments that have not been given directly to the Director or placed in the payment mailbox located in the Youth Center.
A statement of your account will be issued to you on Friday's. This statement may be used as your receipt.

_____ **LATE OR UNPAID TUITION:** There will be an additional $30.00 fee for any payment not received by the close of business on Friday and another $10.00 for each additional day. When making a late payment please add the $30.00 fee to your regular payment when paying on Monday and an additional $10.00 for every day thereafter and follow the normal payment procedure. I understand that if my account is delinquent for more than one week, I may be asked to withdraw my child until my account is made current. The Before / Aftercare Program cannot guarantee a child's spot will be held when a child is withdrawn due to non-payment of tuition. Any unpaid tuition fees may be sent to a third party collection agency.

_____ **CHARGES AND PROCEDURE FOR LATE PICK-UP:** My school is open from 6:00 am to 6:30pm, Monday through Friday all year, except for holidays. I understand that if I fail to pick up my child by the scheduled closing time, I will be charged a late fee of $15 per every 15 minutes or portion of fifteen-minute period, per child until the child is picked up. This fee must be paid in cash to the teacher when the child is picked up.

_____ **RETURNED CHECKS:** I understand that a processing fee will be charged to my account for all checks which are returned for any reason, and this fee is in addition to any charges that my bank or financial institution may charge me. I understand that any-non-sufficient funds checks will be automatically resubmitted electronically up to three times. I further understand that once a check has been processed electronically, the check is no longer negotiable and will not be returned. If more than two checks are returned within a six-month period, I will be required to pay by an alternate method of payment for the next six month period.

DAILY PROCEDURE

_____ **ILLNESS:** I understand that I will be notified should my child becomes ill during the day, and that I will pick up my child promptly, or make arrangements for an authorized emergency contact person to pick up upon such notification. If my child is exposed to or contracts a contagious disease, I agree to notify the school and I understand that my child will be re-admitted according to the Re-admission Criteria in the Family Handbook.

Please do not bring your child to the before / aftercare program when they have the following illnesses or symptoms.

Severe or persistent coughing
Constant runny nose with green or yellow mucus
Fever (100 F and higher)
Vomiting
Yellowish skin or eyes
Unusual spots or rashes that have been checked by a physician
Infected patches
Diarrhea
Gray or white stool
Unusual dark, tea-colored urine
Sore throat or trouble swallowing
lethargic, listlessness (child not feeling themselves)
Lice, nits or untreated ringworm
Communicable diseases (chicken pox, conjunctivitis (pinkeye), mumps, measles, influenza) Discharge from eyes or ear

_____ **WITHDRAWAL FROM PROGRAM:** I understand that I must provide a two (2) week written notice of withdrawal from the program. If this notification is not provided, I agree to pay all tuition and fees for two (2) weeks, whether or not my child attends. I understand that when my child is withdrawn, she/he will only be eligible for re-admission based upon space availability and all other enrollment criteria.

_____ **CHILD ABUSE:** We are required by law to report to the local Social Services Office any suspected physical, emotional, sexual or suspected abuse or neglect.

_____**BEHAVIOR MANAGEMENT AND DISCIPLINE:** No physical punishment will be used. Discipline is enacted on an individual basis. In many cases the word "NO" dissolves the problem. If a child does not listen, talks back. Etc., the child will be placed in a time out to think about their actions. If your child in endangering other children (hitting, kicking, biting or scratching) they will be turned over to the Director and the parents will be notified. We will use redirection for misbehavior and be teaching the children conscious discipline. Please help show your child that you respect us, the rules of our center, and our property by reminding them that the rules still apply when you are around. We will also remind them of the rules and correct them if needed.

_____ **MEDICATIONS:** Medication must have permission from a doctor, form is in the packet.

HOLIDAYS, ABSENCES AND CLOSINGS

_____ **HOLIDAYS:** I understand that the before / after care is closed on the following days:

President's Day
Good Friday
Easter Monday
Memorial Day
Independence Day
Columbus Day
Christmas Day
Day after Christmas

New Years Eve closing @ noon
New Years Day
Martin Luther King Day
Labor Day
Veterans Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve closing @ noon

I agree that I will not receive a refund, credit or any other allowance for holidays. If a holiday falls on a weekend, it will be observed on either the preceding Friday or following Monday. Please note that if the program is closed on Monday all tuition payments must be made the previous Friday before closing to avoid late fee.

ABSENCES/VACATIONS: I agree to inform the before / afterschool program immediately if my child will be absent on any day. I understand that no allowances, credits, refunds, or make up days shall be made for occasional absences (i.e. sickness)

INCLEMENT WEATHER OR OTHER DISASTERS: I understand that the school will following the PG County Public School closing schedule for inclement weather. If PG County Schools are open two (2) hours late, then the school will be open at 8:45 am. If PG County Schools are going to close early due to inclement weather, then I will be required to contact the school to see what time I will need to pick my child up by. I agree that in the event that the school is closed for an extended period of time, I will continue to be responsible for my tuition payments. Should the school be closed on a tuition payment day, I understand that my tuition will be due on the following business day should the school be open.

We do not discriminate based on disability in the admission/enrollment or access to our programs or services. Information concerning the provisions of the Americans with Disabilities Act (ADA), including the rights provided hereunder, is available from the Director.

These policies have been reviewed with me by the Before & Aftercare Program Director. I understand and will comply with the policies. The policies in this contract will supersede all other previous documents.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

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 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896 - february_2014.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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.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:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.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 th ere 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		
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ No	**Test #1** **Test#2**	**Test # 1** **Test #2**

_____ has had a complete physical examination and any concerns have been noted above.

(Child's Name)

Additional Comments: _____

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____ / ____ / ____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

_____ / _____ / _____
STREET A DRESS (with Apartment Number) CITY STATE ZIP

answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

~~Test Date~~	~~Type (V=venous, C=capillary)~~	~~Result (mcg/dL)~~	~~Comments~~

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. 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.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
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

Frederick (Continued)
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

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
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

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT NAME _____ PHONE NO. _____
OR
GUARDIAN 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
1									1				Mo/Yr
2									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.

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 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)