



**Best Buddies Learning Center @ White Marsh Inc**

**Admission Agreement**

By signing, below we agree that I/we have received a copy, carefully read, and agree to all terms and conditions stated in the parent handbook for Best Buddies Learning Center Inc. This includes tuition, late fees, termination notice, parent responsibilities, and ground rules.

I/ We hereby express agreement with all information stated in the parent handbook and accept them as conditions for enrollment of our child(ren) in this day care facility. **A one-month notice is required before terminating** our child's enrollment at Best Buddies Learning Center. Should I/we fail to give ample notice, I/we will be responsible to pay the additional one month of tuition.

In the event of an accident, it is understood that the personnel and Best Buddies Learning Center will not be held responsible. I/We have received a copy of "A Parent's Guide to Regulated Child Care." I/We give Best Buddies Learning Center permission to take pictures of our child(ren) to be shared with us, other families, and for advertising purposes without our child's full name stated in the captions.

This signed admission agreement must be accompanied by a non-refundable tuition payment for enrollment. All tuition is to be paid in advance before service is rendered. No refunds will be made due to absences, illnesses, holidays, field trips, vacations, unforeseen emergencies, or inclement weather forced closings. Should legal action be required due to non-payment of tuition, the responsible parents/guardians will be responsible for all legal fees incurred by the center. The Admission Agreement and nonrefundable deposit are valid for the projected starting date only.

Child's Name: \_\_\_\_\_ Child's Birthday: \_\_\_\_\_

Projected Start Date: \_\_\_\_\_

Contracted Hours of Care: Drop off time: \_\_\_\_\_ Pick-up Time \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Parent/Guardian Email(s): \_\_\_\_\_

Parent/Guardian Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number(s): \_\_\_\_\_

**In order to hold your child's spot this signed contract, the enrollment fee, and the first week's tuition must be made.**

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:	W:
			H:	Employer:
		Email:	C:	W:
			H:	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 \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_

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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 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

Birth date:

Mo / Day / Yr

Sex

M  F

Child's Name:

Last

First

Middle

Address:

Number

Street

Apt#

City

State

Zip

Phone Number(s)

Parent/Guardian Name(s)

Relationship

W:

C:

H:

W:

C:

H:

Medical Care Provider

Name:

Address:

Phone:

Health Care Specialist

Name:

Address:

Phone:

Dental Care Provider

Name:

Address:

Phone:

Health Insurance

Yes  No

Child Care Scholarship

Yes  No

Last Time Child Seen for 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	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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? (Nebullizer, 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

<b>Child's Name:</b> Last: _____ First: _____ Middle: _____	<b>Birth Date:</b> Month / Day / Year _____	<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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:
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## MARYLAND DEPARTMENT OF HEALTH 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

### BOX B - For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the 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
	Make a selection:		
	Make a selection:		
	Make a selection:		

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: \_\_\_\_\_

## 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)

<u>Allergany</u>	<u>Baltimore Co. (Continued)</u>	<u>Carroll</u>	<u>Frederick (Continued)</u>	<u>Kent</u>	<u>Prince George's (Continued)</u>	<u>Queen Anne's (Continued)</u>
ALL	21212	21155	21776	21610	20737	21640
	21215	21757	21778	21620	20738	21644
<u>Anne Arundel</u>	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		<u>Garrett</u>	<u>Montgomery</u>	20752	<u>Somerset</u>
21225	21229	<u>Charles</u>	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	<u>Harford</u>	20812	20782	<u>St. Mary's</u>
	21237	20662	21001	20815	20783	20606
<u>Baltimore Co.</u>	21239		21010	20816	20784	20626
21027	21244	<u>Dorchester</u>	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	<u>Frederick</u>	21082	20868	20790	
21085	21286	20842	21085	20877	20791	<u>Talbot</u>
21093		21701	21130	20901	20792	21612
21111	<u>Baltimore City</u>	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	<u>Howard</u>	<u>Prince George's</u>	<u>Queen Anne's</u>	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	<u>Caroline</u>	21758		20712	21620	<u>Washington</u>
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						<u>Wicomico</u>
						ALL
						<u>Worcester</u>
						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.



**Best Buddies Learning Center:**  
*Student Biography*

The purpose of this form is to allow you the opportunity to share information about your child and their family that will enable your child's teacher to gain a deeper understanding of their strengths and needs as they start a new school year.

**Students FULL Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_  
**Number of Siblings, Names, & Ages:** \_\_\_\_\_

**Parents Occupations:** \_\_\_\_\_  
**Important Family Dynamics** (i.e. recently moved, living with or cared for by another family member, separated/divorced parents, siblings with special needs, etc.) \_\_\_\_\_

**Strategies used at home to sooth and calm your child** (i.e. favorite "lovie", hugs, giving them space, etc.) \_\_\_\_\_

**Child's favorite play activities** (i.e. Legos, trains, books, etc.) \_\_\_\_\_

**Three of your child's strengths:** \_\_\_\_\_

**Three goals you have for your child to focus on this year:** \_\_\_\_\_

**Is there anything else you would like for us to know about your child?** \_\_\_\_\_

# Best Buddies Modified Diet

Food Item	Yes	No	Comment
100% Juice- Apple			
100% juice- white grape			
Animal crackers			
Applesauce			
Bananas			
Blueberries			
Bread / Muffins			
Cheerios			
Cheez-its			
Cheese-sliced			
Chocolate pudding			
Cupcakes			
Chex			
Diced Peaches			
Graham crackers			
Goldfish			
Jelly			
Mandarin Oranges			
Nutigrain bars			
Pancakes			
Peanut Butter			
Ranch Dressing			
Raisins			
Saltine crackers			
String Cheese			
Toast			
Vanilla Pudding			
Yogurt			
Waffles			
Whole milk			
1% Milk			
<b>Holiday Parties</b>			
Cheese Curls/Puffs			
Cookies			
Veggie Sticks			
Strawberries			
Mixed fruit			
Ice cream			





**Maryland State Department of Education  
Office of Child Care  
Medication Administration Authorization Form**

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**  
 This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's  
Picture Here  
(optional)

**PRESCRIBER'S AUTHORIZATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If PRN, for what symptoms, how often and how long \_\_\_\_\_

Possible side effects and special instructions: \_\_\_\_\_

Known Food or Drug Allergies:  Yes  No If yes, please explain: \_\_\_\_\_

For School Age children only: The child may self-carry this medication:  Yes  No

The child may self-administer this medication:  Yes  No

PRESCRIBER'S NAME/TITLE

Place Stamp Here (Optional)

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

**PARENT/GUARDIAN AUTHORIZATION**

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. School Age Child Only: OK to Self-Carry/Self-Administer  Yes  No

PARENT/GUARDIAN SIGNATURE

DATE (mm/dd/yyyy)

INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

CELL PHONE #

HOME PHONE #

WORK PHONE #

**CHILD CARE STAFF USE ONLY**

- Child Care Responsibilities:
1. Medication named above was received. Expiration date \_\_\_\_\_  Yes  No
  2. Medication labeled as required by COMAR.  Yes  No
  3. OCC 1214 Emergency Form updated.  Yes  No  N/A
  4. OCC 1215 Health Inventory updated.  Yes  No  N/A
  5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.  Yes  No  N/A
  6. Staff approved to administer medication is available onsite, field trips  Yes  No

Reviewed by (printed name and signature): \_\_\_\_\_

DATE (mm/dd/yyyy)





# Best Buddies Learning Center

## All About Me

Mother's Name: \_\_\_\_\_

Mother's Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Number: \_\_\_\_\_

Allergies: \_\_\_\_\_

### Emergency Contacts (In order to be called)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

### Feedings

My child drinks

- Formula
- Breaks Milk
- Whole Milk (For children 12-24 months)
- 1% Milk (For Children 2 years and up)

### For Infants/Toddlers

- My child holds their own bottle (Sippy cup used once 12 months old)
- Drinks from a sippy cup
- Drinks from a regular small cup with no lid
- My child uses a pacifier (For under 12 months only)
- Eats baby food
- Eats table food

My infant/toddler eats every \_\_\_\_\_ hours (for children under 12 months)

My child prefers their bottles

- Warmed with bottle warmer
- Room Temperature
- Cold



# Best Buddies Learning Center

How does your child go down for a nap

- Independently
- Needs gently reminders to lay down but will eventually go to sleep on own
- Needs someone to sit with them and pat them
- Needs someone to rock them to sleep

Your child's Bathroom Skills

- Diapers
- Pull ups (with detectable sides only)
- Potty training but wears pull up/diapers and needs reminders
- Potty training with underwear but needs reminders
- Mastered Potty training and able to go on their own

Is your child a good napper at home and where do they sleep? (alone or with someone)

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What do you do to calm your child down when they are upset?

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Goals you have for your child to accomplish?

---

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Areas of difficulty you would like to work on with your child and our team?

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I give permission to BBLC to use my child's picture on their website or Facebook page.  
If you do not give permission please check one or both of the below boxes.

- I do NOT give permission for BBLC to use my child's picture on their website
- I do NOT give permission for BBLC to use my child's picture on their social media (Facebook, etc.)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date