Before & After CARE

GLA Academy

"School of Excellence"

2022-2023

Start Date: _____ Service Fee Amt: _____ Registration Amount: _____ Today's Date:_____

GLA Academy "School of Excellence"

God's Little Angels Academy
GLA Youth Church *** Building Youth Inc.
6247 Kenwood Avenue * Rosedale, MD 21237-2020
Phone: 410~866-0018 or 1091 Fax: 443~772-3517

Student's Information

Name: (Last) _____(First)_____DOB:_____
Address:_____
Street City State Zip
School Attending: _____ Grade:_____ Age ____ Male ___ Female___
Social Security Number: _____-_____-_____ (Application will be denied without SSN)
Vouchers: Y_____ N_____ If yes, voucher #:_____ Exp.Date:_____
Is this a Foster Child: _____No _____Yes (If yes, Worker's name and number):_____
Will they be visiting the child? Yes _____ No _____

Parent/Guardian Information

Mother's Name: _____Cell#:_____
Address:_____ Work #:_____
Father's Name: _____Cell #:_____
Address:_____ Work #:_____

Emergency Contact Information (A person **NOT** mentioned above)
Name: _____ Relationship: _____
Can Pick Up? _____Y _____ N Telephone #:_____
Name: _____ Relationship: _____
Can Pick Up _____Y _____ N Telephone #:_____

Medical Emergency Contact Information

Child Physician or Source of Health Care:_____
Telephone #:_____

For EMERGENCIES requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. You signature on the latter portion of this application authorizes the responsible person at GLA to have your child transported to that hospital by car, ambulance, or aid car. My child may also be given emergency treatment by the appropriate GLA staff.

Transportation Information (If Applicable)

Is Transportation Needed? ___No ___Yes – If so, please give all necessary details:_____
_____
_____

Medical Section (Complete all questions)

Is the student in general good health? No_____ Yes_____ If No, please explain:_____
Does this student have asthma? No_____ Yes _____
Is the student on medication? No_____ Yes _____ For What: _____
Is the student allergic to any foods? No _____Yes _____ What: _____
Does the student have any other allergies? No _____ Yes_____ To What: _____
Date of last tetanus or (DTP) shot: _____
Is the student in good general health? Yes_____ No _____ If NO, explain: _____
Physician's Name: _____ Phone #: _____
Is the student currently enrolled in a Maryland school, public or private? Yes_____ No_____Which?_____
Are there any behavioral challenges that we should know about? _____

Additional Fees:

- $1.00 per minute late pick up fee, Charge is per child and will be added to weekly balance due.
- $5.00 per day late payment fee. Charge is for unpaid balances after Monday and is due at next payment
- $45.00 return check charge for all checks returned.
- $95. / $130 nonrefundable registration fee for enrollment.
- Transportation, Before/After School and Drop-in Care. Fees are additional

Universal Field Trip Permission

I hereby request that my child be permitted to participate in field trips such as discovery walks, the library, parks or any other activities that would involve taking the child outside of the center for his/her benefit in attendance at this facility. I understand that my child will be traveling in vans, buses and cars owned and operated by God's Little Angels, Inc and Building Youth Inc., and/or any other contracted transportation companies. Your signature at the bottom of this application serves as your agreement.

Waiver Release Form

In exchange for participation in all daily activities such as; trip, walks, library visits, dance, step, swimming, karate, sports, games, running, walking, lining up, eating, playing, falling, hitting/biting with other children, water play, bowling, skating, go carting, transportation and ect. Organized by God's Little Angels, Inc/ Building Youth, Inc., I agree for myself, my family and all third Parties that:

- We will observe and agree to all posted rules and warnings and further agree to follow any oral instructions or directions given.
- We will accept that there are certain inherent risks associated with the aforementioned activities and we assume personal responsibility for personal injury and release GLA from injury, loss or damage.
- We will agree to defend GLA against all claims, causes of action damages, judgments, attorney's fees and other costs which may arise.
- We will agree to pay for all damages to the facilities that may result from our negligence. And,
- We will agree that any/all legal actions that may arise shall be resolved under GLA guidelines.

Your signature at the bottom serves as your agreement.

Illness Procedures & Self Medication Policy

Any Illnesses such as; pink eye, stomach virus, hacking cough, colds with green and yellow mucous, fever, viruses, flu vomiting or any contagious disease the child will be isolated from the rest of the group. The parent will be contacted immediately. The child must be picked up within an hour after the emergency call is made. The child will need a doctor's note to return back to school unless an okay is given by a school administrator. **If your** child is on medication for a documented illness, your health practitioner must complete and validate a medication order form. Medication will not be administered without this form. Children on maintenance drugs such as albuterol inhaler will be supervised while administering the drug. Your signature at the bottom serves as your agreement.

SUMMER CAMP STUDENTS:

Building Youth Inc/GLA will not administer any medication to students/campers. Parents are responsible for ensuring that their child (ren) is/are well versed on how to self-administer medication. In the event that the student/camper is unable to do so, parents/guardians must have an alternate available to come to our site to administer medication. **Your signature at the latter portion of this application notes that you understand clearly that God's Little Angels/ Building Youth Inc will not administer any medication to students/campers. Payment Policy:**

Payment Policy

No refunds will be issued. Overpayments will remain as a credit on your account. All Payments are due on Monday in advance. You must pay for the ENTIRE week, whether or not you use the service (transportation Included). Parents are responsible for full payment during the Christmas and Easter week vacation. A free week form must be completed and signed by a GLA finance person. A two week notice must be given if you withdraw your child (ren) from any of the GLA programs. Otherwise you will be responsible for two weeks of payment. If your vouchers expire and your children are still attending the programs you are responsible for the entire payment. (No exceptions) If you receive vouchers or cash assistance towards your tuition and have already made a payment a credit will be issued to your account. No cash refunds will be issued. GLA has the right to terminate services of any reason that causes any disruption that may affect the flow of business.

Co-payments must be paid each week in advance. Registration fees are non-refundable.

Persons signing contract are responsible for payment; I understand that this is a legally binding contract, and I have read it and understand it.

Parent/Guardian (Signature): _____ **Date:** _____

Social Security Number: _____-_____-_____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment : Yes:_____No:_____
Days & Hours : Mon___Tues__Wed__Thurs___Friday___

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

DEPARTMENT OF HUMAN RESOURCES

Child Care Administration

ALL ABOUT: _____

Child's First Name or Nickname

Child's Name: _____ Birthdate: _____

Parent/Guardian: _____ Telephone: _____ Work: _____

Address: _____ Zip: _____

Provider/Center: _____ Telephone: _____

Address: _____ Zip: _____

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 THES 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: _____

DHR/CCA 8506 (6/98) Side 2 of 2

God's Little Angels
Disciplinary Procedures

Our Ultimate goal in the area of student behavior is to have all students exercise age appropriate self-discipline. Age appropriate self-discipline means to behave in a manner that is appropriate for that child's particular age and stage development. However, some children may need more time to develop. As we know, each child develops at their own rate. It is our goal at God's Little Angels Learning Center, in collaboration with the child's parent/guardian, to assist in the positive re-enforcement of age appropriate self-discipline by taking the following steps to ensure that each student is ale to learn in a safe and nurturing environment, free from challenging behaviors that impede the student's learning, their peers learning and safety, and also the teacher's ability to manage the classroom in a safe, nurturing and academically acceptable space. Therefore, if a student's behavior(s) becomes challenging for the teacher to maintain a safe, nurturing and academically acceptable environment the following is the procedure the teacher will take:

1. The teacher will have a private talk with the student to try to refocus the student.

2. If the behavior continues then age appropriate self-reflection is suggested which is, one minute per age.

3.The teacher will seek administrative assistance, if the challenging behaviors continue.

The Director will take the following actions depending on the severity of the behavior(s) exhibited, each step is progressive if the behaviors continue:

1. Have a talk and or walk with the student.

2. Call the guardian to give the student some words of encouragement to return to class in a positive manner.

3. Have a conference with the teacher and guardian, that may result in the transfer of the student to a new classroom (if space is available). Subsequently a weekly behavior plan will be created and charted.

4. Send the student home for up to three (3) days on a disciplinary removal if warranted.

5.The student will be removed PERMANTLY from God's Little Angels Learning Center.

Date: _____ Student's Printed Name: _____

Parent's Printed Name: _____

Parent's Signature: _____

Important School and Before/After care Guidelines

All students must wear a mask each day

*It is important that all the forms in the packet is completed in its entirety. If you need any assistance with a form, please see the front office.

*To keep our students as safe as possible no one is allowed in the building except for students and staff.

*All students must be signed in and out each day.

*If a student is experiencing any Covid 19 symptoms they will be sent home for the day. We may request that the student takes a covid test and has a negative result to return to school.

*If a child tests positive for Covid we may close the school building and the students will continue with sessions online. All students will need a negative covid test to return.

I acknowledge that I have read and understood the above policies and procedures in its entirety and agree to abide by them.

Child's Name: _____

Parent Name: _____

Parent Signature_____ **Date:** _____

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

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
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

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

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 AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

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

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____