



**THE WINCHESTER SCHOOL**  
3223 Bel Pre Road  
Silver Spring, Maryland 20906  
(301) 598-2266  
thewinchesterschool.org

### **REGISTRATION CHECKLIST**

To complete registration and reserve a space for your child for the 2025-2026 school year:

1. Please complete the following forms and return with your registration asap:
  - a. **Application for Admission**
  - b. **Enrollment and Tuition Agreement**
  - c. **Summer Registration** (if attending summer camp)
  - d. **Emergency Form** (OCC 1214) – if your child has a medical condition which might require emergency medical care, your child’s doctor’s signature may be required
  
2. Please have your child’s doctor complete the following forms and return by August 15<sup>th</sup>:
  - a. **Health Inventory** (OCC 1215) – required for all children
  - b. **Medication Administration Authorization** (OCC 1216) – required if Winchester is to administer medication for your child
  - c. **Seizure Medication Administration Authorization** (OCC 1216A) – if applicable
  - d. **Allergy Action Plan and Asthma Medication Administration Authorization** – if applicable

All forms are available for download from the school website: [thewinchesterschool.org/forms](http://thewinchesterschool.org/forms)

3. A check made out to the **Winchester School** for the registration fee and the deposit should be submitted as soon as possible to secure a space for your child. Enrollment is on a first-come, first-served basis.
  
4. **By August 15, 2025**, you must submit the **Health Inventory form and any other applicable forms from step 2 above filled out and signed by your child’s doctor**. If your child doctor’s appointment is scheduled after August 15<sup>th</sup>, please inform Ms. Khadija immediately.

Please contact Ms. Khadija at school if you have any questions regarding registration.



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### APPLICATION FOR ADMISSION

Student's Full Name \_\_\_\_\_ Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Class: \_\_\_\_\_ (Pre-K3/Pre-K4/K/1<sup>st</sup>/2<sup>nd</sup> grade)

The Maryland State Department of Education age regulation states that a Pre-K3 child must be 3 on September 1<sup>st</sup> of the school year in which the child applies for entrance. Similarly, a Pre-K4, Kindergarten, First Grade or Second Grade applicant must be 4, 5, 6, or 7, respectively.

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Title: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

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

Title: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Allergies/Medications/Special Conditions: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission to take your child on field trips supervised by teachers and parents? Yes: \_\_\_ No: \_\_\_

Permission to post your child's picture on Winchester website/social media? Yes: \_\_\_ No: \_\_\_

How did you hear about Winchester? (Social media, search engine, drive by, friend, mail, ad, etc.):

\_\_\_\_\_

If referred, name of person who referred: \_\_\_\_\_

Enroll in: Full \_\_\_ (7:30am-6:00pm) Academic \_\_\_ (8:45am-3:00pm) Half \_\_\_ (8:45am-noon)

My child will \_\_\_ / will not \_\_\_ / may \_\_\_ attend the summer program.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\* A non-refundable \$85 registration fee must accompany this application. \***



**THE WINCHESTER SCHOOL  
ENROLLMENT AND TUITION AGREEMENT  
2025 – 2026 Academic Year**

**Student Full Name:** \_\_\_\_\_

**Parent/Guardian Names:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I hereby enroll the above named student in The Winchester School for the 2025-2026 school year, which is from August 26, 2025 through June 17, 2026. I understand and agree that the period of enrollment and tuition obligation shall be for the entire school year, or in the case of a student's entering after the school year has begun, from the date of admission to the last day of the school year.

I understand and agree that there will be no reduction in the tuition obligation in the event of student absence, withdrawal or dismissal or any other reason including weather-related closings/reduced hours.

Students are expected to behave with due regard for the rights and feelings of others. The school reserves the right to dismiss a student whose scholarship, conduct, or cooperation is unsatisfactory.

Parents are expected to respect and uphold school policies and regulations in the Winchester School Parent Handbook and the contractual agreement they have with the school. The school reserves the right to ask parents to remove their child from the school if said parents disregard or fail to uphold school policies, regulations, the terms of the contractual agreement, or misrepresent their child or themselves in any way.

Tuition for the 2025-2026 school year for Pre-K, Kindergarten, First and Second grades is:

- \$17,433 for full-day (\$1,835/month) from 7:30am – 6:00pm
- \$15,770 for academic-day (\$1,660/month) from 8:45am – 3:00pm
- \$8,930 for half-day (\$940/month) from 8:45am-noon (3 year olds only)

For student enrollment to be guaranteed for the 2025-2026 school year, this agreement must be signed by the parent or guardian financially responsible for the student and returned to the Winchester School along with a deposit equal to one month tuition and the \$85 registration fee. The deposit is not refundable under any circumstances.

The balance of the tuition owed for the school year will be paid in 9 installments at the beginning of each month beginning on August 26, 2025, with the last installment equivalent to ½ month tuition made on May 1, 2026. The tuition installments are **due on the first school day of the month**. When payment is received after **the third school day** of the month, a late fee of \$75 will be charged.

Signature of Parent or Guardian

By: \_\_\_\_\_

Date: \_\_\_\_\_

Accepted: The Winchester School

By: \_\_\_\_\_

Date: \_\_\_\_\_



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## **2025 SUMMER CAMP INFORMATION**

1. The summer program runs from June 18, 2025 through August 15, 2025.
2. Summer hours are 8:00am to 5:00pm.
3. Tuition is \$459 per week and is due on the Monday beginning the week. There are no partial weeks allowed.
4. Children should arrive no earlier than 8:00am and no later than 8:45am to start the day.
5. Children should be picked up no later than 5:00pm. A late fee of \$15 per 15 minute increment (or fraction thereof) will be charged for late pick-ups.
6. Each week will have a theme, activities and special events which may include: circle time; story time; musical activities; arts and crafts; science activities; organized playground games; board games; water play (via sprinklers), field trips (requiring parent volunteers to drive and chaperone); and some limited work with letters and numbers.
7. For new 3 and 4 year-old students entering Winchester in the fall, a minimum of 2 consecutive weeks of summer camp is mandatory. Children do much better in the fall when they enter Winchester alongside their friends from summer. Winchester is likely more of a “teaching” school than most children have experienced before so we like to acclimate them slowly to the more formal, yet stimulating, school environment.
8. Up-to-date forms including Health Inventory, Emergency Form and Medication Administration Authorization (if applicable) are required prior to a child entering summer camp. All of these forms may be found on the Winchester School website under “Forms”.
9. Parents are required to send sunscreen to school for their child.
10. Children must be fully potty-trained prior to entering Winchester and may not be sent to school in pull-ups.

We strive to maintain consistency between the school year and summer staff to ensure a comfortable environment for the children.

Any questions about the summer program should be directed to Ms. Khadija.



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## 2025 SUMMER CAMP INFORMATION

To register your child for the Winchester School summer program, please fill out and return this sheet. This form should be submitted as soon as possible to ensure a space for your child as we enroll on a first-come, first-served basis.

Note: For students new to Winchester, a minimum of 2 consecutive weeks of summer camp is mandatory prior to entering the school year program to acclimate your child to the school.

My child \_\_\_\_\_ will be entering the \_\_\_\_\_ (3 year old, 4 year old, Kindergarten, 1<sup>st</sup> grade, 2<sup>nd</sup> grade) program in September.

He/she will be attending the following weeks in the summer program:

1. \_\_\_\_\_ June 16 -18 and 20 (\$367 for 4 days since June 19<sup>th</sup> is a national holiday)
2. \_\_\_\_\_ June 23 – 27
3. \_\_\_\_\_ June 30 - July 3 (\$367 for 4 days since July 4<sup>th</sup> is a national holiday)
4. \_\_\_\_\_ July 7 – 11
5. \_\_\_\_\_ July 14 – 18
6. \_\_\_\_\_ July 21 – 25
7. \_\_\_\_\_ July 28 – August 1
8. \_\_\_\_\_ August 4 – 8
9. \_\_\_\_\_ August 11 – 15

I **will**\_\_\_ / **will not**\_\_\_ be willing to drive and chaperone for a field trip.

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

\_\_\_\_\_  
Date

Phone: \_\_\_\_\_  
Home

\_\_\_\_\_  
Cell

Email: \_\_\_\_\_

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 \_\_\_\_\_

**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

# 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**

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b>
Last		First		Middle	
_____			Mo / Day / Yr		M <input type="checkbox"/> F <input type="checkbox"/>
<b>Address:</b>					
Number		Street		Apt#	City
_____		_____		_____	State
_____		_____		_____	Zip
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>		<b>Phone Number(s)</b>	
_____		_____		W: _____	C: _____
_____		_____		W: _____	C: _____
<b>Medical Care Provider</b>		<b>Health Care Specialist</b>		<b>Dental Care Provider</b>	
<b>Name:</b> _____		<b>Name:</b> _____		<b>Name:</b> _____	
<b>Address:</b> _____		<b>Address:</b> _____		<b>Address:</b> _____	
<b>Phone:</b> _____		<b>Phone:</b> _____		<b>Phone:</b> _____	
				<b>Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child Care Scholarship</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Last Time Child Seen for Physical Exam:</b> <b>Dental Care Specialist:</b>	
<b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.					
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>		
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"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b>					
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> 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.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
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>			<b>Birth Date:</b>			<b>Sex</b>	
Last	First	Middle	Month / Day / Year			M <input type="checkbox"/>	F <input type="checkbox"/>
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child receive care from a Health Care Specialist/Consultant? <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
4. Health Assessment Findings							
<b>Physical Exam</b>	<b>WNL</b>	<b>ABNL</b>	<b>Not Evaluated</b>	<b>Health Area of Concern</b>	<b>NO</b>	<b>YES</b>	<b>DESCRIBE</b>
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:			
<b>REMARKS:</b> (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? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis: <b>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).</b> <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a>							
7. Should there be any restriction of physical activity in child care? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
8. Are there any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
9. <b>RECORD OF IMMUNIZATIONS</b> – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 896.)							
10. <b>RECORD OF LEAD TESTING</b> - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 4620)  Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.							

Additional Comments: \_\_\_\_\_

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

# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

CHILD'S NAME: \_\_\_\_\_  
LAST
FIRST
MI

SEX: MALE  FEMALE  BIRTHDATE: \_\_\_\_\_  
MM/DD/YYYY

PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

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

1. _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> <span>Name</span> <span>Title</span> </div> <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> <span>Signature</span> <span>Date</span> </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"><b>Clinic/Office Name, Address, Phone</b></div> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
2. _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> <span>Name</span> <span>Title</span> </div> <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> <span>Signature</span> <span>Date</span> </div>	

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

Lead Risk Assessment Questionnaire Screening Questions:

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

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

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

\_\_\_\_\_  
Parent/Guardian Signature
Date

# MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

## How To Use This Form

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

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

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

## Frequently Asked Questions

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

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

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

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

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

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

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

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

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

Maryland and local jurisdictions have programs for families with a child exposed to lead:

- Maryland Home Visiting Services for Children with Lead Poisoning
- Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

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

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

Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.

Phone: (610) 519-3478 or Toll Free: (833) 362-2243

Website: <https://www1.villanova.edu/university/nursing/macche.html>

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

Place Child's  
Picture Here  
(optional)

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.**

**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
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CELL PHONE #	HOME PHONE #	WORK PHONE #
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**CHILD CARE STAFF USE ONLY**

Child Care Responsibilities:	1. Medication named above was received. Expiration date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Medication labeled as required by COMAR. <input type="checkbox"/> Yes <input type="checkbox"/> No 3. OCC 1214 Emergency Form updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 4. OCC 1215 Health Inventory updated. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

Place Child's Picture  
Here (optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
**Page 1 to be completed by the Authorized Health Care Provider.**  
**FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216**

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of plan:** \_\_\_\_\_  
 Child has **Allergy** to \_\_\_\_\_  Ingestion/Mouth  Inhalation  Skin Contact  Sting  Other \_\_\_\_\_  
 Child has had anaphylaxis:  Yes  No  
 Child has asthma:  Yes  No (If yes, higher chance severe reaction) Child  
 may self-carry medication:  Yes  No  
 Child may self-administer medication:  Yes  No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
<b>is Not exhibiting or complaining of any symptoms, OR</b>		
<b>Exhibits or complains of any symptoms below:</b>		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Throat*:</b> difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
<b>Lung*:</b> shortness of breath, repetitive coughing, wheezing		
<b>Heart*:</b> weak or fast pulse, low blood pressure, fainting, pale, blueness		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Other:</b>		
<b>If reaction is progressing (several of the above areas affected)</b>		

\*Potentially life threatening. The severity of symptoms can quickly change\*

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) **Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
<b>PRESCRIBER'S SIGNATURE</b> (Parent/guardian cannot sign here) (original signature or signature stamp only)		<b>DATE</b> (mm/dd/yyyy)

Maryland State Department of Education  
Office of Child Care  
**Allergy and Anaphylaxis**  
**Medication Administration Authorization Plan**

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

PARENT/GUARDIAN AUTHORIZATION			
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #		HOME PHONE #	
		WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3. OCC 1214 Emergency Card updated	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	6. Individualized Plan: IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/___	3. Child's picture (optional)
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**Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

4. ASTHMA SEVERITY:  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise Induced  Peak Flow Best \_\_\_%

5. ASTHMA TRIGGERS (check all that apply):  Colds  URI  Seasonal Allergies  Pollen  Exercise  Animals  Dust  Smoke  Food  Weather  Other \_\_\_\_\_

6. This authorization is **NOT TO EXCEED 1 YEAR FROM** \_\_\_/\_\_\_/\_\_\_ **TO** \_\_\_/\_\_\_/\_\_\_ **FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216**

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer  Yes  No

**GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated**

The Child has <b>ALL</b> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)					

**Exercise Zone**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

The Child has <b>ANY</b> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it					

**YELLOW ZONE - GETTING WORSE**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

The Child has <b>ANY</b> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)					

**RED ZONE - MEDICAL ALERT/DANGER**  CALL 911  CALL PARENT  OTHER: \_\_\_\_\_

The Child has <b>ANY</b> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)					



**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ____/____/____
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**Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

8. PRESCRIBER'S NAME/TITLE		Place Stamp Here		
TELEPHONE	FAX			
ADDRESS				
CITY	STATE	ZIP CODE		
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)				9b. DATE (mm/dd/yyyy)

**Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN**

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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 childcare 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 childcare 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

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION	
10d. CELL PHONE #	10e. HOME PHONE #	10f. WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

**Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM**

Child Care Responsibilities:	1. Medication named above was received Expiration date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
	2. Medication labeled as required by COMAR <input type="checkbox"/> Yes <input type="checkbox"/> No	
	3. OCC 1214 Emergency Form updated <input type="checkbox"/> Yes <input type="checkbox"/> No	
	4. OCC 1215 Health Inventory updated <input type="checkbox"/> Yes <input type="checkbox"/> No	
	5. Modified Diet/Exercise Plan <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	7. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No	

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

**MEDICATION ADMINISTRATION LOG**

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:					Date of Birth:	
MEDICATION	DATE	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE