



MTT Before and Aftercare

Pre-Registration Form

The annual registration fee of \$125 is non-refundable. The registration fee and one week tuition MUST be paid in advance of enrollment.

Parent Full Name: _____

Phone Number: _____

Email: _____

Name of Registered School (*i.e., Melwood, Benjamin Starter, etc.*):

Child's Date Of Birth:

Number of Students Enrolling: _____

Child(ren) Name: _____

Desired Care:

- ☐ Before Only
- ☐ After Only
- ☐ Both

Desired Start Date: _____

Parent/Guardian Signature : _____



ACKNOWLEDGMENT OF ENROLLMENT DEPOSIT

To HOLD SPACE

The deposit guarantees you space for your child (or children) in the appropriate classroom(s) when space becomes available. Enrollment space is reserved and secured with a deposit for up-to 2-months to the desired start date of enrollment.

Your deposit will be held for one day (24 hours) in order to allow parents to read through and understand the Enrollment Agreement. A signed Agreement returned within 24 hours ensures the child's place and commits the parent(s) to all policies and procedures. If the agreement is returned unsigned within 24 hours, it is assumed that the child is not enrolled. No space will be held and the deposit check will be returned.

If an Agreement is not returned within 24 hours --signed or unsigned, the space is forfeited and the deposit is forfeited. _____ (Initial)

If a space is available immediately in the appropriate classroom, the parent(s) may fulfill all of the requirements as soon as possible, the same day if necessary, and the child may be enrolled in the class.

A space is not held without a deposit. Your deposit is credited to your first week of tuition.

Be advised, that tuition rates are subject to change ANYTIME during the space-withholding period.

The deposit required to reserve a space is \$ _____. The child will be enrolled in the classroom.

A deposit in the amount of \$ _____ has been received from _____ (PRINT) to reserve a space for _____,

(Child's Name)

(Child's Name)

Deposit received on _____ at _____

(Date)

(Time _am/pm).

This deposit will be held for 24 hours from the time noted above. A signed Agreement must be returned within 24 hours to ensure your child's space. Failure to return an unsigned Agreement within 24 hours will result in a forfeiture of the deposit in full. _____ (initial)

I understand and agree to the terms above.

Parent Name (PLEASE PRINT) _____

Parent's Signature _____ **Date** _____ **Time** _____

Email _____ **Phone #** _____

Center Director's/Assistant Director's Signature _____ **Date** _____



Before and Aftercare Agreement SY 2025-26

This Before and Aftercare Agreement ("Agreement") is entered into between Mom's Tiny Treasures ELC, and the parent/guardian, _____ for the provision of before and aftercare services for the child, _____.

1. Program Details: 1.1 The Provider agrees to provide before and/or aftercare services for the Child(ren), as specified in the registration form. **Hours:** Contracted HOURS for care will be from (i.e.) 6:00 am -7:30 am (Before) _____ to _____ and/or (After) 2:00 pm – 6:00 pm _____to_____ on the days specified in **Addendum A**. Full day drop-in rate will apply for days when schools are closed.

2. Payment and Fees: 2.1 The Parent/Guardian agrees to pay the specified fees for the before and aftercare services as communicated by the Provider. 2.2 Payment is due every Friday and will be made under the agreed-upon payment terms. Payments received on Monday are considered late. If a holiday falls on a Friday, payment is due by the next business day. 2.3 **NO Checks** are accepted. Payments are only accepted in the form of Cash (USD) or online using a secure platform (e.g., Portal, Zelle). 2.4 A **fee of \$25.00** will be charged daily for late payments.

3. Attendance and Schedule: 3.1 The Child's attendance schedule for the before and aftercare program shall be as specified in the registration form. 3.2 The Parent/Guardian agrees to notify the Provider in advance of any changes to the Child's attendance schedule. 3.3 We follow the PGCPs Calendar for closures. For additional details, please see our holiday and closure calendar.

4. Pick-up and Drop-off: 4.1 The Parent/Guardian is responsible- **see attached Addendum A** for further details. 4.2 If someone other than the Parent/Guardian is designated to pick up the Child, the Provider must be informed in advance and appropriate identification provided before the release of the child.

5. Health and Emergency Care: 5.1 The Parent/Guardian agrees to provide accurate and up-to-date medical and emergency contact information for the Child. 5.2 In case of a medical emergency, the Provider is authorized to seek medical treatment for the Child and to inform the Parent/Guardian as soon as possible.

6. Behavior Management: The program staff will use positive reinforcement and constructive guidance to manage behavior. Persistent behavioral issues may result in suspension or termination from the program. See our Behavioral Policy.

7. Code of Conduct: 7.1 The Child is expected to adhere to the rules and guidelines set forth by



the Provider for the safety and well-being of all participants. 7.2 Any behavior that poses a danger to others or disrupts the program may result in disciplinary actions or removal from the program.

8. Electronic Devices Policy: To ensure the safety and security of electronics and valuables(e.g. cell phones, tablets, video games, money, and jewelry) students must keep them in their book bags. MTT will not be held responsible for loss, damages, theft, or cost/expense.

9. Termination of Agreement: 9.1 Either party may terminate this Agreement with written notice. Two weeks' Notice is required. 9.2 The Provider reserves the right to terminate the Child's participation immediately due to non-compliance with program rules or other reasons affecting the safety and operation of the program.

10. Liability and Waiver: 10.1 The Parent/Guardian acknowledges that participation in the before and aftercare program involves certain risks and releases the Provider from liability for any injuries or accidents that may occur during the program. We are not responsible for any lost or damaged devices 10.2 The Provider will take reasonable precautions to ensure the safety of the Child but cannot be held responsible for circumstances beyond their control.

EMERGENCY INFORMATION

If a parent cannot be contacted, please list at least one person who can be notified in case of an emergency.

Name _____ Phone _____ Relationship to Child _____

Name _____ Phone _____ Relationship to Child _____

Please list all people who can pick the child up from care without the written consent of the parent (note government-issued ID REQUIRED before the release of the child)

1. _____ 2. _____

By signing below, the Parent/Guardian acknowledges that they have read, understood, and agreed to the terms and conditions of this Before and Aftercare Agreement.

Parent/Guardian's Full Name: _____ Signature: _____

Date: _____ Email: _____

Provider's Representative: _____ Signature: _____

Date: _____

This Agreement is effective as of the date signed by both parties and remains in effect until terminated as specified herein.

Child Care Scholarship Program Clause

Child Care Scholarship Terms and Conditions:

1. Scholarships are awarded based on financial need and availability of funds.
2. If tuition payment is not received by the Office of CCS within **21 days**, the parent is responsible for paying the full amount owed including applicable fees. Care is subject to being paused until payment is received.
3. Applicants must submit all required documentation and complete the scholarship application process by the specified deadline.
4. Scholarship recipients may be asked to provide additional information or documentation for verification purposes.
5. The awarded scholarship amount will be applied toward the program's weekly tuition amount.
6. Scholarships are not transferable and are applicable only to the child named in this registration form.
7. Incomplete or inaccurate information may result in the denial of the scholarship application.
8. MTT Early Learning Center reserves the right to no longer
9. By applying for a scholarship, you grant permission to MTT to verify the information provided on the scholarship application.

I acknowledge that I have read, understood, and agreed to the terms and conditions outlined above regarding the childcare scholarship program.

Parent/Guardian's Signature: _____

Date: _____

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 ChildAddress _____
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 FirstAddress _____
Street/Apt. # City State Zip Code2. Name _____ Telephone (H) _____ (W) _____
Last FirstAddress _____
Street/Apt. # City State Zip Code3. Name _____ Telephone (H) _____ (W) _____
Last FirstAddress _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner _____ Date _____

Signature of Health Practitioner () _____
Telephone Number _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:
[http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland immunization certification form dhmh 896 - february 2014.pdf](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](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 <input type="checkbox"/> M <input type="checkbox"/> F									
Address: _____ Last _____ First _____ Middle _____ Mo / Day / Yr _____									
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 Name: _____ Address: _____ Phone # _____				Your Child's Routine Dental Care Provider Name: _____ Address: _____ Phone _____				Last Time Child Seen for Physical Exam: _____ Dental Care: _____ Any Specialist: _____	
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge, the child is:									

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.		Any Specialist :
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	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<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"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening Allergic 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"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<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, 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: _____			Birth Date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Last	First	Middle	Month / Day / Year			

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> 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:
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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 _____ / _____ / _____
 CHILD'S ADDRESS _____ 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
☐ 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: _____

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>Allegany</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.

Allergy Action Plan

Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

Place Child's
Picture Here

TREATMENT

Symptoms:

The child has ingested a food allergen or exposed to an allergy trigger:

Give this Medication

Epinephrine

Antihistamine

But is **not** exhibiting or complaining of any symptoms

Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")

Skin: hives, itchy rash, swelling of the face or extremities

Gut: nausea, abdominal cramps, vomiting, diarrhea

Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough

Lung*: shortness of breath, repetitive coughing, wheezing

Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness

Other:

If reaction is progressing (several of the above areas affected)

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

*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication	Dose:
Epinephrine:	
Antihistamine:	
Other:	

Doctor's Signature _____

Date _____

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: _____ Phone Number: _____

Contact(s)	Name/Relationship	Phone Number(s)	
		Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration

I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

Parent/Guardian's Signature _____

Date _____

Allergy Action Plan (Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's
Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

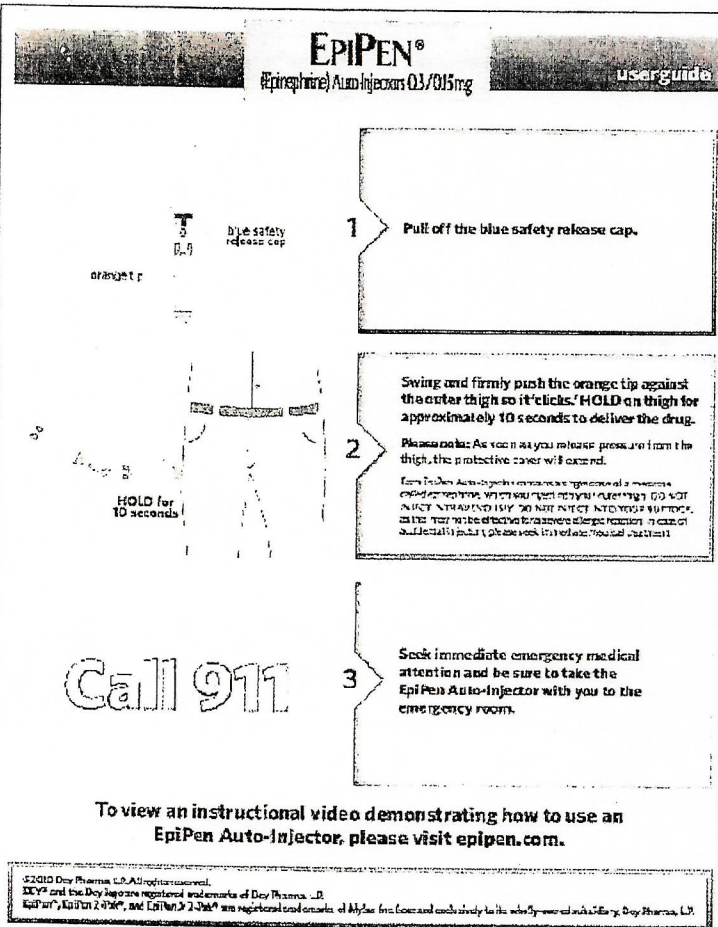
Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food, _____)
- ☐ Ensure proper hand washing procedures are followed. _____
- ☐ Observe and monitor child for any signs of allergic reaction(s). _____
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) _____
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity. _____
- ☐ _____

The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication. _____
- ☐ Replace medication prior to the expiration date. _____
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed. _____
- ☐ _____



EPIPEN®
EpiPen® Auto-Injector 0.3/0.15mg

1 Pull off the blue safety release cap.

2 Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.
Please note: As soon as you release pressure from the thigh, the protective cover will extend.

3 Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

Call 911

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

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Challenging Behavioral Policy

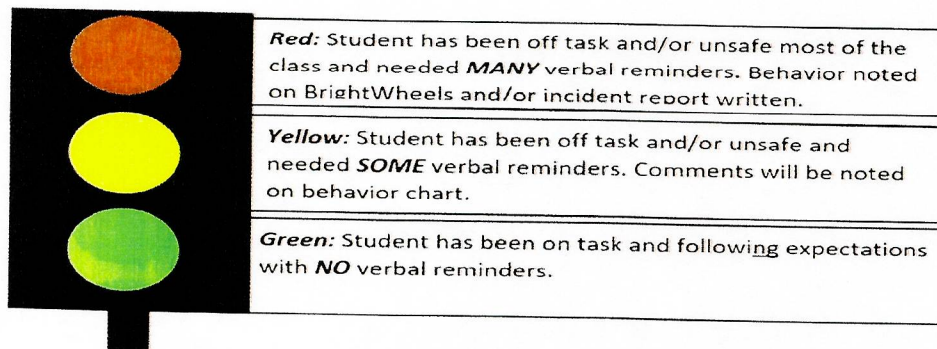
The Staff at Mom's Tiny Treasure Early Learning Center will provide each child with guidance to help the child acquire a positive self-concept and self-control, as well as teach acceptable behavior. Behavior guidance will be used to demonstrate positive and acceptable behaviors. While maintaining standards based upon the developmental needs of each student. Staff will give positive focus and affirmation to encourage desired behaviors suited to the age of the child. Children are guided to treat each other and adults with respect and kindness.

Each child at MTT has the right to:

- *Learn in a safe and friendly place*
- *Be treated with love and respect*
- *Receive the help and support of a caring professionally trained staff*

When a child demonstrates inappropriate behavior, we intervene immediately to protect all of the children and bring a sense of immediate calm. Our approach to helping our tiny treasures with challenging behaviors is to show them how to solve problems using appropriate interactions. When redirection is necessary, it is clear, consistent, and is understandable based on the age of the child. We use "time-out" sparingly and prefer strategies that give the child safer control; yet safety over themselves and their space. For example; we may have a child sit on an "alone rug" and have them play constructively with a toy, puzzle or other object. There will be no use of corporal punishment in our facility, or any negative physical touching (spanking, slapping, pinching, etc.). No unusual punishment will be allowed, such as humiliation, ridicule, threat or coercion. Withholding of food, clothing, or medical care will not be used as punishment nor tolerated by any members of the staff. We also maintain a zero tolerance to bullying. If you have any concerns about this at any time, please report it to the Owner or Director of the Center.

Daily Behavior Chart





Physical Restraint

Physical restraint is not used or permitted for discipline. No physical restraints of any kind will be used on any child.

Notification of Behavioral Issues to Families

If a child's behavior/circumstance is of concern, communication will begin with the parents as the first step to understanding the child's individual needs and challenges. We will work together to evaluate these needs in the context of our program.

On rare occasions, a child's behavior may warrant the need to find a more suitable setting for care. Examples of such instances include:

- A child appears to be a danger to others and or self.
- Continued care could be harmful to, or not in the best interest of the child as determined by medical, psychological, or social service personnel.
- Undue burden on our resources and finances for the child's accommodations for success and participation in a structured learning environment.

**For more information about the behavior policy, please reference MTT's Parent Handbook.*

By signing below, I acknowledge that I have read, understood, and agreed to the terms and conditions outlined above regarding the behavior policy.

Child's Name: _____
Parent's Name: _____ Date: _____
Parent's Signature: _____

There are certain requirements that apply only to homes or centers.

Family Child Care Homes

- Up to 3 children may be in care at the same time if the home meets certain physical requirements. No more than 2 children under the age of two, including the caregiver's own, may be in care at the same time unless the home has been approved to serve additional children in this age group and an additional adult is present. Under no circumstance may care be provided at the same time to more than 4 children under the age of two.
- Each applicant for a family child care license must:
 - Have a criminal background check and child abuse/neglect clearance.
 - Submit a recent medical evaluation; and
 - Complete pre-service training requirements, including certification in first aid and CPR.
- Each adult resident of the home must also have a criminal background check and child abuse/neglect clearance.
- After becoming licensed, the caregiver must periodically complete additional training. Also, current certification in first aid and CPR must be maintained at all times.
- Each caregiver must have at least one substitute who is available to care for the children in the event of the caregiver's temporary absence from the home. Each substitute is subject to approval by OCC and must have a child abuse/neglect clearance. If paid by the caregiver, a substitute must also have a criminal background check. Before allowing a substitute to provide care, the caregiver must tell the substitute how to reach parents in the event of an emergency and familiarize the substitute with the home's child health and safety procedures.

Child Care Centers

The center director and staff members who have group supervision responsibilities must meet minimum education, experience, and training qualifications. They must also meet continued training requirements each year.

The director and all paid center employees must complete a criminal background check and a child abuse/neglect clearance, and submit a medical evaluation.

In each classroom, staff/child ratio and maximum group size requirements must be maintained at all times. The following table shows some basic age groupings and the applicable requirements:

Age Group	Ratio	Maximum Size
0 - 18 months	1:3	9
18 - 24 months	1:3	9
2 years	1:6	12
3 - 4 years	1:10	20
5 years or older	1:15	30

For every 20 children present, there must be at least one staff member who is currently certified in first aid and CPR.

Your Rights and Responsibilities as a Child Care Consumer

- You have the right to:
 - Expect that your child's care meets the standards set by Maryland's child care licensing regulations (NOTE: the regulations are available online at: www.marylandpublicschools.org/MSDE/divisions/child_care/regulat/).
 - Visit the facility without prior notification any time your child is there.
 - See the rooms and outside play area where care is provided during program hours.
 - Be notified if someone in the family child care home smokes. In child care centers, smoking is prohibited.
 - Receive advance notice when a substitute will be caring for your child in a family child care home for more than two hours at a time.
 - Give written permission before a caregiver may take your child swimming, wading, or on field trips.
 - Give written authorization before any medication may be administered to your child.
 - Be notified immediately of any serious injury or accident. If your child has a non-serious injury or accident, you must be notified on the same day.
 - File a complaint with OCC if you believe that the caregiver has violated child care regulations.

Any complaint you make to OCC about the care your child is receiving will be promptly investigated by OCC. Review the public portion of the licensing file for the facility where your child is or has been enrolled, or where you are considering enrolling your child.

How Do I File a Complaint?

If you wish to file a complaint, contact the OCC Regional Office in the area where the child care facility is located. Complaints may be filed anonymously. Listed below are Regional Offices and their main telephone numbers:

Region	
1 - Anne Arundel County	410-514-7850
2 - Baltimore City	410-554-8300
3 - Baltimore County	410-583-6200
4 - Prince George's County	301-333-6940
5 - Montgomery County	240-314-1400
6 - Howard County	410-750-8770
7 - Western Maryland	
Hagerstown - Main Office	301-791-4585
Allegany Co. Field Office	301-777-2385
Garrett Co. Field Office	301-334-3426
8 - Upper Shore	410-819-5801
Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties	
9 - Lower Shore	410-713-3430
Somerset, Wicomico, and Worcester Counties	
10 - Southern Maryland	301-475-3770
Calvert, Charles and St. Mary's Counties	
11 - North Central	410-272-5358
Cecil and Harford Counties	
12 - Frederick County	301-696-9766
13 - Carroll County	410-751-5438

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated.

If you need additional help, you may contact the main office of the OCC Licensing Branch:

Program Manager, Licensing Branch
MSDE Office of Child Care
200 West Baltimore Street, 10th Floor
Baltimore, MD 21201
410-767-7805

Parent/Guardian:

* Maryland child care regulations require your child care provider to verify that you received a copy of "A Parent's Guide to Regulated Child Care." On the lines below, please write the name of each child you have placed in the care of this provider. Complete and sign the statement at the bottom, tear off and give this portion of the brochure to the child care provider for retention in the facility's files.

Child: _____

Child: _____

Child: _____

Child: _____

I, _____, have received a copy of the consumer education brochure entitled "Parent's Guide to Regulated Child Care."

Date _____

Signature of Parent/Guardian _____



PHOTO RELEASE FORM

Dear Parents,

Your child will be participating in various activities, events, and fun learning experiences while attending our center. We often take photos to post in the classroom, use for crafts or to share them on our social media page.

Social media is a great way to keep you updated on important events and center information while allowing you to see the fun experiences your child is enjoying. Be sure to follow us on our social media platforms.

Please indicate below if you give us permission to use your child's photo.

_____ I GIVE permission to take and use my child's photo for the reasons listed above.

_____ I DO NOT GIVE permission to take and use my child's photo for the reasons listed above.

Parents Signature _____ **Date** _____

Parent - Provider Transportation Agreement

I, _____, give permission for my child care provider, or
(Name of parent)

any approved employee of the above program, to transport my child(ren)

_____, _____

(Name(s) of child(ren))

for the following reasons (check all that apply):

_____ Field trips

_____ Excursions to the park

_____ Emergency purposes

_____ Any reason deemed necessary by the program

It is agreed that:

1. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.
4. Any motor vehicle used to transport my child(ren) will have current registration and inspection stickers, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. The caregiver will notify me in advance of any instance where my child(ren) will be transported while in care.

(Parent or Guardian) (Date)

(Provider/Director) (Date)

Prince George's County Public Schools 2025-2026 School Calendar

APPROVED JANUARY 2025

2025	
July 4	Independence Day – Schools and Offices Closed
August 13-15	Professional Duty Days for New Teachers
August 18-22	Professional Duty Days for All Teachers
August 25	Student Orientation Day (Professional Duty Day for All Teachers)
August 26 (Tuesday)	First Day of School for All Students
September 1	Labor Day – Schools and Offices Closed
September 12	Teacher Planning, Half-Day – Early Dismissal for Students
September 23	Rosh Hashanah* (starts at sunset 9/22)
September 23	Professional Development – Schools Closed for Students
October 2	Yom Kippur* (starts at sunset 10/1)- Schools and Offices Closed (Potential inclement weather make-up day ¹)
October 17	Professional Development – Schools Closed for Students
October 18- 23	Diwali*
October 31	End of First Quarter (45 days)
October 31	Grading & Reporting Day Q1 for Teachers – Early Dismissal for Students
November 11	Parent-Teacher Conferences – Schools Closed for Students
November 26-28	Thanksgiving Break – Schools and Offices Closed
December 19	Teacher Planning, Half-Day – Early Dismissal for Students
December 22-31	Winter Break & Christmas Holiday – Schools and Offices Closed
2026	
January 1	New Year's Day – Schools and Offices Closed
January 2	Winter Break – Schools and Offices Closed
January 19	Martin Luther King Jr. Day – Schools and Offices Closed
January 26	End of Second Quarter (46 days)
January 26	Grading & Reporting Day Q2 for Teachers – Early Dismissal for Students
February 13	Teacher Planning Half-Day – Early Dismissal for Students
February 16	Presidents' Day – Schools and Offices Closed
February 18	First Day of Ramadan* (starts sunset of 2/17)
March 18	Last Day of Ramadan*
March 20	Eid al-Fitr* (starts sunset of 3/19)
March 20	Professional Development – Schools Closed for Students (Potential inclement weather make-up day ¹)
March 27	End of Third Quarter (42 days)
March 27	Grading & Reporting Day Q3 for Teachers – Early Dismissal for Students
March 30- April 2	Spring Break – Schools Closed
April 1- 9	Passover* (starts sunset of 4/1)
April 3 & 6	Spring Break/Easter Holidays – Schools and Offices Closed
April 22	Teacher Planning, Half-Day – Early Dismissal for Students
May 25	Memorial Day – Schools and Offices Closed
May 27	Eid al-Adha* – Schools and Offices Closed (Potential inclement weather make-up day ¹)
June 12	Last Day for Students¹ and End of Fourth Quarter (47 days) – Early Dismissal for Students
June 15, 16 & 17	Potential Inclement weather make up days that may be used if instructional days need to extend the year ¹
June 16	Last Day for Teachers ¹
June 19	Juneteenth – Schools and Offices Closed

IMPORTANT CALENDAR NOTES – There are 180 student days and 192 teacher days (195 for new teachers). Last days for students and teachers are subject to change. 10- and 11-month employees can refer to Bulletin M-1-23 for clarification on workdays.

¹**INCLEMENT WEATHER MAKE-UP DAYS** –If the school year is disrupted by emergencies and schools are closed, dates identified as possible make-up instructional days include: October 2, 2025, and March 20, May 27, June 15, June 16, June 17, 2026. If no emergency closure days occur, the school year will end for students on Friday, June 13, 2026, as shown.

Please note that if more emergency closures occur than there are available make-up days and/or there are a significant number of delayed openings and/or early dismissals used, the school calendar also may be adjusted appropriately to meet the minimum required student days AND the required number of student hours.

²**EARLY RELEASE DAYS** - There are grading and reporting days and planning days throughout the school year. On these days (September 12, October 31, December 19, January 26, February 13, March 27, April 22, and June 12), our students are dismissed early so our school professionals can complete other duties. [View early dismissal times](#)

***RELIGIOUS HOLIDAYS** – Major religious holidays are noted here for planning purposes. Many Jewish and Muslim holidays begin the day before at sunset. PGCPs recognizes and values the diversity of traditions represented among its staff and students. The religious practices and observances of students and employees, and is committed to providing reasonable accommodations for religious obligations.