



# Little Seedlings Mother's Day Out

A ministry of  
First Saints Community Church  
St. Paul's Campus  
P.O. Box 2260  
Leonardtown, MD 20650  
301-475-5050  
[www.littleseedlings.org](http://www.littleseedlings.org)  
[littleseedlings@firstsaints.org](mailto:littleseedlings@firstsaints.org)

Dear Parents,

We are excited to welcome you to Little Seedlings Mother's Day Out Program! I will be keeping in touch with you by email as we prepare for the first day. Please review the following information and attached. If you have any questions, don't hesitate to contact me.

## **Forms Required by Maryland State Department of Education – Early Childcare Division:**

***Health Inventory*** - Doctors MUST complete the lead screening section which requires a blood test. Please read the form carefully and have your child's doctor read the Blood Lead Testing Certificate Page and complete fully.

***Immunization Record*** – All immunizations must be up to date. The Doctor's office can give you a copy of their record or a computer generated report. I've included a copy of the current immunizations requirements for your information. If your student is on a delayed immunization schedule or you have a religious objection, this must be clearly indicated on the Health Inventory form.

***Emergency Form*** – Please be sure to have at least one emergency contact person. It's also important that we have your child's doctor's name, address and phone number on the Emergency Contact Form.

## **Forms Required by Little Seedlings MDO:**

*Child Pick-Up to include all adults who have permission to pick your student up from school.*  
*All About My Child*

**The Little Seedlings Website:** You can find our website at [www.littleseedlings.org](http://www.littleseedlings.org)  
Mother's Day Out forms are available under the MDO tab.

We look forward to welcoming you and your child (children) to our program. We will be in touch!

God bless,

Georgia Gray,  
Director

**Please email or mail your forms to Little Seedlings postmarked by *August 4<sup>th</sup>, 2023***

*"Growing the Seeds of Our Future"*

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MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:  No:

Meals your child will receive while in care:  
 BK  LN  SU  AM Snk  PM Snk  Evng Snk

**EMERGENCY FORM**

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
		Email:	C:	W:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) \_\_\_\_\_  
 Last First Relationship to Child

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES**

\_\_\_\_\_  
 (Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Last First

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
 Street/Apt. # City State Zip Code

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

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

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

**INSTRUCTIONS TO PARENT/GUARDIAN:**

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

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

Medical Condition(s): \_\_\_\_\_  
\_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_  
\_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_  
\_\_\_\_\_

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

(3) To prevent incidents: \_\_\_\_\_  
\_\_\_\_\_

-----  
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



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Student Name \_\_\_\_\_

## Child Pick-Up

The following individuals have permission to pick up my child from Little Seedlings Christian Preschool and Kindergarten. [Please include your names (Mother's and Father's) also.]

Name	Relationship	Phone No.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that if someone listed above is unknown to Little Seedlings staff, identification will be required before a child will be released. All individuals should have ID available at dismissal time.

Someone other than those listed above may take a child home **only** if we have received written permission from a parent/guardian.

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

**"Growing the Seeds of Our Future"**

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MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

# HEALTH INVENTORY

## Information and Instructions for Parents/Guardians

### REQUIRED INFORMATION

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

- **A physical examination** by a health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations.** The immunization certification form (MDH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at: <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms> Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. <https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms>

### EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

### INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan, 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

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>
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:	
Medical Care Provider Name: Address: Phone:	Health Care Specialist Name: Address: Phone:	Dental Care Provider Name: Address: Phone:	Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Child Care Scholarship <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Time Child Seen for Physical Exam: Dental Care: Specialist:	
<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.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism	<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	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<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, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<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"/>			
Sensory Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
Does your child receive any special treatments? (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					
Does your child require any special procedures? (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.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					Date _____



**PART II - CHILD HEALTH ASSESSMENT**  
To be completed **ONLY** by Health Care Provider

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, 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:							
<b>4. Health Assessment Findings</b>							
<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	<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	<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	<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	<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 Disorder	<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.)							
<b>5. Measurements</b>		<b>Date</b>		<b>Results/Remarks</b>			
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: (OCC 1216 Medication Authorization Form must be completed to administer medication in child care). <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 <u>or</u> 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: