



# 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)  
[mdo@firstsaints.org](mailto:mdo@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. If you have any questions, don't hesitate to contact me.

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

***Health Inventory*** – Completed by your child's doctor.

***Maryland Department of Health Blood Lead Testing Certificate*** – Completed by your child's doctor.

***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. If your child 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*** - *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 3rd, 2026.***

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



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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"

# Tell Us More About Your Child...

Child's Name and D.O.B: \_\_\_\_\_

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

Sibling Name(s) & Age: \_\_\_\_\_

Pet Name(s): \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

What activities does your child enjoy? \_\_\_\_\_

Is your child left or right handed? \_\_\_\_\_

What skills does your child do well? \_\_\_\_\_

What skills are you working on with your child? Any Challenges/Anxieties? \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

Comfort item to be used at MDO and what does your child call it? \_\_\_\_\_

Have you begun toilet training at home? \_\_\_\_\_

If yes, what words do you use? How does your child communicate that they need to use the restroom? \_\_\_\_\_

Sit or stand? \_\_\_\_\_

Is there any part of the process that causes your child anxiety? \_\_\_\_\_



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## Little Seedlings Mothers Day Out Parent Handbook

The Little Seedlings Mothers Day Out Parent Handbook is available on our school website  
[www.littleseedlings.org](http://www.littleseedlings.org) under the MDO Tab.

<https://img1.wsimg.com/blobby/go/d1144aa4-92cc-4cbc-96b1-f69a4139ea64/downloads/Mothers%20Day%20Out%20Parent%20Handbook%202023%3A2024.pdf?ver=1690807810009>

Please read our Handbook carefully. If you have any questions about the information in the handbook, please don't hesitate to ask. Paper copies of the Handbook will be available upon request.

I have access to the Parent Handbook and agree to follow all school policies and procedures.

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

*"Growing the Seeds of Our Future"*

MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

## HEALTH INVENTORY

### Information and Instructions for Parents/Guardians

#### REQUIRED INFORMATION

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

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

#### EXEMPTIONS

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

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

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

#### INSTRUCTIONS

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

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: <https://health.maryland.gov/Pages/Home.aspx#>

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: <https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program>

**PART I - HEALTH ASSESSMENT**  
**To be completed by parent or guardian**

Child's Name:			Birth date:		Sex		
			Last	First	Middle	Mo / Day / Yr	M <input type="checkbox"/> F <input type="checkbox"/>
Address:							
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 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? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.)</b> <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? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)</b>							
<input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan							
<b>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>							
<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"/>																																																																																																																																																	
<p><b>1.</b> 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:</p> <p><b>2.</b> Does the child receive care from a Health Care Specialist/Consultant?  <input type="checkbox"/> No   <input type="checkbox"/> Yes, describe</p> <p><b>3.</b> 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:</p> <p><b>4. Health Assessment Findings</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; padding: 5px;"><b>Physical Exam</b></th> <th style="width: 15%; padding: 5px;"><b>WNL</b></th> <th style="width: 15%; padding: 5px;"><b>ABNL</b></th> <th style="width: 15%; padding: 5px;"><b>Not Evaluated</b></th> <th style="width: 30%; padding: 5px;"><b>Health Area of Concern</b></th> <th style="width: 10%; padding: 5px; text-align: center;"><b>NO</b></th> <th style="width: 10%; padding: 5px; text-align: center;"><b>YES</b></th> <th style="width: 15%; padding: 5px; text-align: center;"><b>DESCRIBE</b></th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">Head</td><td style="padding: 5px;"><input type="checkbox"/></td><td style="padding: 5px;"><input type="checkbox"/></td><td style="padding: 5px;"><input type="checkbox"/></td><td style="padding: 5px;">Allergies</td><td style="padding: 5px;"><input type="checkbox"/></td><td style="padding: 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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:	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																
<b>REMARKS:</b> (Please explain any abnormal findings.)																																																																																																																																																						
<b>5. Measurements</b>		Date		Results/Remarks																																																																																																																																																		
Tuberculosis Screening/Test, if indicated																																																																																																																																																						
Blood Pressure																																																																																																																																																						
Height																																																																																																																																																						
Weight																																																																																																																																																						
BMI % tile																																																																																																																																																						
Developmental Screening																																																																																																																																																						
<p><b>6.</b> 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></p>																																																																																																																																																						
<p><b>7.</b> 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:</p>																																																																																																																																																						
<p><b>8.</b> Are there any dietary restrictions?  <input type="checkbox"/> No   <input type="checkbox"/> Yes, specify nature and duration of restriction:</p>																																																																																																																																																						
<p><b>9.</b> <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 or 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.)</p>																																																																																																																																																						
<p><b>10.</b> <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)</p> <p>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.</p>																																																																																																																																																						

Additional Comments:

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:
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## Vaccine Requirements for Children

Enrolled in Preschool Programs and in Schools — Per COMAR 10.06.04.03

Maryland School Year 2025 - 2026

(Valid for the 2025-2026 academic and summer school year.) rev 2/18/2025

### Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs

Child's Current Age	Vaccine	DTaP/DTP/DT <sup>1,6</sup>	Polio <sup>2</sup>	Hib <sup>3</sup>	Mumps, Rubella	Measles, <sup>2,4</sup> Mumps, Rubella	Varicella <sup>2,4,5</sup> (Chickenpox)	Hepatitis B <sup>2</sup>	PCV <sup>3</sup> (Prevnar™)
<b>Less than 2 months</b>	0	0	0	0	0	0	0	1	0
<b>2 - 3 months</b>	1	1	1	1	0	0	0	1	1
<b>4 - 5 months</b>	2	2	2	2	0	0	0	2	2
<b>6 - 11 months</b>	3	3	2	2	0	0	0	3	2
<b>12 - 14 months</b>	3	3	At least 1 dose given after 12 months of age		1	1	1	3	2
<b>15 - 23 months</b>	4	3	At least 1 dose given after 12 months of age		1	1	1	3	2
<b>24—59 months</b>	4	3	At least 1 dose given after 12 months of age		1	1	1	3	1
<b>60 - 71 months</b>	4	3	0	0	2	2	1	3	0

### Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12<sup>th</sup> grade

Grade Level (Ungraded)	DTaP/DTP/Tdap/ DT/Td <sup>1,6</sup>	Tdap <sup>2</sup>	Polio <sup>2</sup>	Measles, <sup>2,4</sup> Mumps, Rubella	Varicella <sup>2,4,5</sup> (Chickenpox)	Hepatitis B <sup>2</sup>	Meningococcal (MCV4)
Kindergarten & Grade 1, 2, 3, 4, 5, & 6	(5 - 11 yrs.) 3 or 4	0	3	2	2	2	3
Grades 7, 8, 9, 10, & 11	(11 - 13 yrs.) 3 or 4	1	3	2	2	3	1
Grade 12	(13 - 18 yrs.) 3 or 4	1	3	2	1 or 2	3	1

\* See footnotes on back for 2025-2026 school immunization requirements.

## Vaccine Requirements for Children

### Enrolled in Preschool Programs and in Schools

### Maryland School Year 2025 – 2026

(Valid for the 2025-2026 academic and summer school year.) rev 2/18/2025

## FOOTNOTES

### Requirements for the 2025-2026 school year are:

- 2 doses of Varicella vaccine for entry into kindergarten, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup> and 11<sup>th</sup> grades.

**Instructions:** On the chart locate the student's age or grade and read from left to right on the chart to determine the NUMBER of required vaccinations by age or grade. MMR and Varicella vaccination dates should be evaluated (See footnote #4).

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication to the pertussis-component is required.
2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio, and measles, mumps, rubella and varicella, but revaccination may be more expedient.
3. Hib and PCV (Prevnar™) are not required for children older than 59 months (5 years) of age.
4. All doses of measles, mumps, rubella, and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12<sup>th</sup> grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before the first birthday.
5. Two doses of varicella vaccine are required for students entering Kindergarten, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup>, and 11<sup>th</sup> grades and for previously unvaccinated students 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is a documented history of disease provided by a health care provider. Documentation must include month and year.
6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccine (any combination of the following — Tdap, DT or Td) are required for children 7 years of age and older.
7. Polio vaccine is not required for persons 18 years of age and older to enroll or attend school.

**MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE**

STUDENT/SELF NAME: \_\_\_\_\_

LAST

FIRST

MI

STUDENT/SELF ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: MALE  FEMALE  OTHER

BIRTH DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COUNTY: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

**FOR MINORS UNDER 18:**

PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

#	DTP-DTaP- DT Mo/Day/Yr	Polio Mo/Day/ Yr	Hib Mo/Da y/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr
2	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr
3	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE Mo/Day/Yr
4	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr
5	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr	DOSE Mo/Day/Yr

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name  
Office Address/ Phone Number

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

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Medical provider, local/state health department official, school official, or child care provider only)

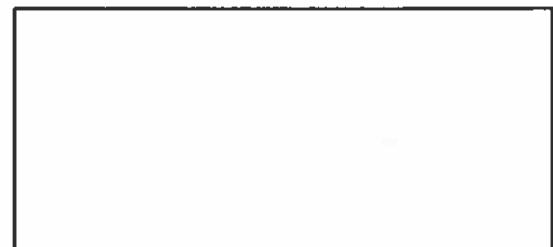
2. \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.



**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

Please check the appropriate box to describe the medical contraindication.

This is a:  Permanent condition OR  Temporary condition until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, \_\_\_\_\_

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

Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

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

MDH Form 896 (Formerly DHMH 896)

Rev. 06/25

Center for Immunization  
www.health.maryland.gov/Imm

## How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

### **Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age-appropriate immunity against *Haemophilus influenzae*, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

**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 ( $\mu$ g/dL)	Comments

**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.	Name _____	Title _____	Clinic/Office Name, Address, Phone _____
	Signature _____	Date _____	
2.	Name _____	Title _____	_____
	Signature _____	Date _____	

**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 ( $\mu\text{g}/\text{dL}$ ). 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  $\geq 3.5 \mu\text{g}/\text{dL}$ , 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

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 &amp; Days of Expected Attendance \_\_\_\_\_

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email: _____	C: _____	W: _____ Employer: _____
		Email: _____	C: _____	W: _____ 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 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_

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

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

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

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

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