1928 Frederick Rd., Catonsville, MD 21228
Phone: 410-455-0386 Fax 410-719-9564
storyquest@verizon.net
www.storyquestclub.com

2018-2019 Before & After School Care Registration

Child's Name _____ D.O.B. _____

Gender: M or F Grade _____ School Attending _____

Home Address _____

City, State, Zip _____ Home Phone _____

Requested Start Date: _____

Mother/Guardian

Name _____

Home Address _____

City, State, Zip _____

Email Address _____ Home Phone _____

Cell Phone _____ Work Phone _____

Father/Guardian

Name _____

Home Address _____

City, State, Zip _____

Email Address _____ Home Phone _____

Cell Phone _____ Work Phone _____

Additional Student Information

Does your child have any special needs that we should be aware of? _____

_____

Does your child have any allergies? _____

_____

Does your child have any of the following:

- ☐ An IEP (Individual Education Plan)
- ☐ A 504
- ☐ An Aide, Assistant, or Scribe

If you checked any of the boxes above, it is Maryland State Law that we have a copy on file. Please submit this at the time of registration.

If you checked any of the boxes above, please briefly explain the reasons for the IEP, 504, or Aide. _____

_____

_____

_____

I am registering my child for:

- ☐ Before Care ($160 per month)
- ☐ After Care ($200 per month)
- ☐ Before & After Care ($350 per month)

One time registration fee $40 and 1st months tuition are due at registration for new students.

By signing this contract, I acknowledge that I have read and agree to the terms on the "Policies" of Story Quest After School Club.

Parent/Guardian Signature _____ Date _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

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

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

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

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ____

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

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

(3) To prevent incidents: ______________________________

____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________________

____

____

____

COMMENTS: ____

____

____

____

____

Note to Health Practitioner:

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

______________________________ Name of Health Practitioner

______________________________ Date

______________________________ Signature of Health Practitioner

(_____)______________________________ Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any Specialist :**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: Last First Middle	**Birth Date:** Month / Day / Year	**Sex** M ☐ F ☐

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	**WNL**	**ABNL**	**Not Evaluated**	**Health Area**	**WNL**	**ABNL**	**Not Evaluated**
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

RELIGIOUS OBJECTION:

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

Parent/Guardian Signature: _____ Date: _____

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ No	**Test #1**	**Test#2**	**Test # 1**	**Test #2**

_____has had a complete physical examination and any concerns have been noted above.

(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

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Phone: 410-455-0386 Fax 410-719-9564
storyquest@verizon.net
www.storyquestclub.com

Notice of Absence

When Story Quest is not made aware of your child's absence from the program, it places a burden on your child's school and our transportation schedule. Therefore, when your child is absent from Story Quest, we ask that you notify our office by 2 p.m.

We prefer you communicate with us by email at StoryQuest@verizon.net. However, if necessary, you may also call our office at 410-455-0386 and leave a message by 2 p.m.

Please cut and return the portion below

Notice of Absence

I have read the above memo and I agree to notify Story Quest by 2 p.m. on the day my child will be absent from the program.

_____ _____
Mother/Guardian Signature Date

_____ _____
Father/Guardian Signature Date

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

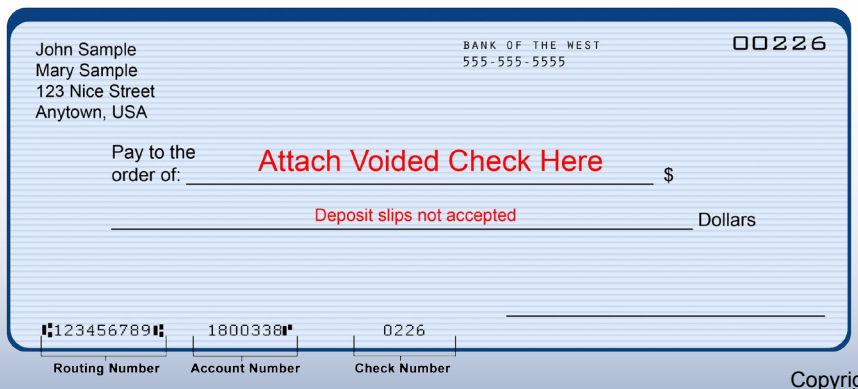
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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