

2011-2012 After School Club
PRE K- 2nd Grade & 3rd Grade-6th Grade
Welcome Package

Thank you for choosing the After School Club as your trusted provider of before & after school programming for your child! United Educational Corporation (UEC) is a 501 C 3 nonprofit organization. Pursuant to Family Law Article, Sections 5-570 through 5-585, COMAR 13 A.16.16COMAR 13 A.16.01.19, Education Article Section 2-206 and Annotated Code of Maryland UEC has a Child Development Program License per the Office of Child Care, Maryland State Department of Education. As we enter our 10th year of programming at The “NEW” Mount Washington School want to share some of the activities we have to offer our participants. Some of the activities include, Arts and Crafts, Sign Language, Recreational Sports, Soccer Club, Drama, Basketball, Cheerleading, Recreational Games, Scrabble Club, Chess Club, Literacy Club, Volleyball, Walking and Exercise Club, and more will be added as interest dictates.

Please take a moment to review each of the enclosed documents for more information on the program. It is extremely important that each parent/guardian read and understand the expectations, routines and procedures.

Again, thank you for the opportunity to provide care for your child, and we look forward to continuing a lasting and mutual rewarding relationship.

Matthew J. Day, Director and Founder

To subscribe to the After School email listserv, please send a blank email to aftercare-subscribe@lists.mtwashingtonelementary.com

Procedures and Routines

PLEASE REMEMBER THAT CELL PHONES ARE NOT PERMITTED FOR STUDENTS!!!

Program Arrival: Students will meet in the designated area below for check in each day.

Pre K- 2nd Graders (LOWER BUILDING) - AUDITORIUM/ GYM

3rd thru 6th Graders (UPPER BUILDING) - CAFETERIA

Before School Program begins at 7:00 am and the After School Program begins at 2:55 pm

Check In: Children will immediately be seated in order for attendance to be taken.

Storage and Belongings: **Lower Building** Pre K, Kindergarten, 1st and 2nd grade students will store their belongings in the labeled bins in the auditorium/gym. **Upper Building** Students grades 3rd-6th will store their items in lockers near the gym. Lockers will be shared by two students. All belongings should be kept in identified lockers and storage bins at all times for the duration of the participant's attendance.

Snack Time: All students will receive a snack after storing their belongings and being checked in.

Supper Time: Supper will be provided for each student at approximately around 4:30 -5:00 pm in the cafeteria.

Activity Sessions: Children will be grouped by age and rotate through different activities in their own age groups.

Child Pick Up: Lower Building Parents/Guardians will park in the parking lot and enter the front door and go to the gym/café to sign out all children. A staff member will locate the students at both locations using radio equipment.

Upper Building Parents /Guardians should park along the right hand curb of the hill of Lochlea next to the school or in the parking lot. Enter the cafeteria to sign out all children. The program ends daily at 6:00 pm. Late pickups will incur a \$1.00 per minute late fee due immediately upon arrival.

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Payment Procedures and Information

Registration Fee: One-time.....\$10.00 per Child * Must be paid by everyone. NO EXCEPTIONS!!

After School Care: Monthly..... \$175.00

Weekly..... \$50.00

Daily..... \$10.00

Before School Care: Monthly..... \$ 75.00

Weekly.....\$25.00

(7am-8:05am in cafeteria)

Payment Dates: **Monthly All payments are due on the first of each month.**

Weekly..... Due on Monday

Half Days: Additional \$10.00..... 11:55-6:00PM

Teacher PD day: Additional \$20.00.....8AM-6:00PM

Holiday camps: \$110 weekly.... 7AM-6:00PM Winter Camp/Spring Camp

Election Day 9/13, 11/8,

PD Days: (10/12, 10/21, 1/26, 1/27, 03/22)

Half Days: (12/14, 5/16)

Payment Methods: DSS Vouchers accepted. Payments can be made by **CHECK OR MONEY ORDER** or online at www.uecorp.org. Please make checks payable to: "United Educational Corp" or "UEC".

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United Educational Corporation Contract / Waiver Information (After School Club)

Must Be Signed Before Child Can Start

I understand that tuition is due Monday of each week or the 1st of each month. I authorize UEC (After School Club) to transport my child during field trips or medical emergencies by car, van or bus. I understand there are no refunds in the event my child is removed from the After School Club. I understand that cell phones/games & electronics are not permitted during the program (before/ after care.)

I agree that I have completed all forms including the Heath History form to best of my abilities.

I hereby grant United Educational Corporation "After School Club" permission to use my child (ren) likeness in a photograph or video for any organization publications without payment or any other consideration.

Parent Consent & Wavier: I and my child (ren) fully recognize the risk of injury, illness or death inherent in participation in all activities during the ASC program in or out of the building. I the legal guardian, give permission for my child (ren) to attend UEC (After School Club). I hereby knowingly assume all risks and dangers inherent and incidental to all activities. I fully understand the chance of an injury during camp. I wave all claims and will not sue or hold United Educational Corporation's After School Club liable for any injuries or damages incurred during all activities inside/outside and field trips in Maryland or Washington D.C.

In case of 911 medical emergencies, I hereby authorize medical personnel to give the necessary treatment to my child. I authorize UEC and staff to administer first aid procedures to my child if needed.

I have voluntary read, accept and understand the guidelines and procedures concerning tuition payments, wavier, medication, first aid, field trips, 911 emergencies and field trips and I fully understand the contents, meaning, and impact of this release

Child 1 Name: _____

Child 2 Name: _____

Parent/ Guardian Signature: _____ Date: _____

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subscribe@lists.mtwashingtonelementary.com](mailto:aftercare-
subscribe@lists.mtwashingtonelementary.com)*

Snapshot of a Few of our Staff Members

Matthew Day, Program Director/Founder

Mr. Day holds a Master of Science Degree in Sports Management from the Virginia Commonwealth University, a Bachelor of Science Degree in Physical Education from Virginia State University, and an Associate's Degree in Teacher Education from Baltimore City Community College. Mr. Day also holds a certification in Administration 1 as well as an Advanced Professional Certificate for grades K-12. Mr. Day has been the Physical Education Teacher & After School Club Director at Mount Washington for the past 9 years. Matthew Day received the Youth Development Award from 40th District Delegate, Shawn Tarrant. Mr. Day has also established many of Mt. Washington's Community based activities, including Family Movie Night, Father/Son & Father/Daughter Basketball Games, Children's Fun Run, and Cheerleading/Basketball Team. He is also First Aid/CPR & Lifeguard Certified.

Fraya Arnett, Assistant Director

Mrs. Arnett attended Coppin State University. She handles all administrative duties for the After School Club including receipt of payments and overseeing communications. Mrs. Arnett has several years experience coaching Women's Volleyball, Track and Basketball. Mrs. Arnett help lead our own Mt Washington Tigers to a 2010 BEBL Championship. Mrs. Arnett is CPR/First Aid certified.

Mark Chinnia, Program Manager

Mr. Chinnia is a college graduate of Towson University with a Bachelor of Science in Social Science. He has over 4 years experience working and teaching in the Baltimore City Public School System. He is a graduate of Loyola High School where he is the former basketball coach. Mr. Chinnia has also run previous basketball camps for Loyola High School. Mr. Chinnia will be a part of the school day staff starting in August 2009. Mr. Chinnia is CPR/First Aid certified.

Robert Lee Hardy, Drama/Theatre

Mr. Hardy holds a Bachelor of Fine Arts from The State University of New York at Purchase. Mr. Hardy has several years experience in acting, teaching, and directing plays throughout Baltimore City. He recently directed a play for the After School Club in which first through fifth grade students worked together to compose and perform a successful event. Mr. Hardy is CPR/First Aid Certified.

James Smith, Assistant/Counselor James

recent high school graduate that attends CCBC. James is a former student of Mount Washington Elementary School who assists with all operations during the after school hours.

Zach Flores, Counselor/ Soccer

Zach is a graduate of Saint Mary's College of California. Zachary is currently a professional soccer player for Maryland Crystal Palace.

Jennifer May, Scrabble Club/Homework Club

Ms. May holds a Master of Science in Education from North Carolina/Greensboro University, and a Bachelor of Science in Exercise and Sports Science. Ms. May has over 8 years of certified teaching experience. Ms. May is also a fifth grade teacher at Mount Washington Elementary School.

Carol Pugh, Chess Club/Homework Club

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Ms. Pugh holds a Bachelor of Science in Education from Coppin State College and is a candidate for a Master of Science in Mathematics at Johns Hopkins University. Ms. Pugh is the organizer of the Mt. Washington Elementary Chess Team. She has over 20 years of teaching experience and is a fifth grade teacher at Mount Washington Elementary School.

Gail Thompson, Parent Volunteer/Counselor

Ms. Thompson is a parent of two children currently attending Mount Washington Elementary and has one child that graduated from our school. Ms. Thompson assists daily with homework, organization, recreation, check out and computer activities. Ms. Thompson attended Baltimore Community College and Computer Certification Center. Ms. Thompson is a certified pharmacy technician.

Kabrina Edmonds, Sign Language

Mrs. Edmonds attends Baltimore City Community College. Mrs. Edmonds has taught Sign Language for the Maryland School for the Blind and several after school programs. Mrs. Edmonds provides clerical services for the school office.

Lamont Sutton, Basketball Coach/Counselor

Lamont is a former student and graduate of BCPSS. Lamont is currently the Basketball Coach for Mount Washington Elementary School Basketball Team who won the Championship this past season. Lamont is CMT, CPR/First Aid certified.

Dwight Washington, Assistant/Volunteer

Mr. Washington holds a Master's Degree of Divinity from Family Bible College, Bachelor's Degree of Theology, and Associates Degree in Biblical Studies. Mr. Washington is the husband of first grade teacher, Mrs. Washington. Mr. Washington assists with check in, homework and recreation. Mr. Washington has worked with the After School Club for 7 years.

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Communicating with Parents & Staff

ASC staff keeps in communication throughout the daily program using handheld high frequency radios (“walkie talkies”) and mobile phone texting.

NO CELL PHONES ARE PERMITTED!!!!

Communication with parents will include emails, mobile (text) messaging, telephone and printed notices (***** Please remember that we are a GREEN SCHOOL so printed notices will be kept to a minimum, most correspondences will be by email. Please make sure to follow the directions at the bottom of the pages of this package to register for the listserv*****). A bulletin board will display current and upcoming information. Flyers will be sent home to inform parents about special events.

Parents are encouraged to contact the program staff using email. Staff may also be reached via the cell phone. Parents must notify the staff when any changes are necessary with a child’s schedule, etc. Questions will be addressed promptly.

Matthew Day (443) 804 – 4209 or matt@uecorp.org
Fraya Arnett (443) 858 - 3709 or farnett@uecorp.org
Gail Thompson (410) 952 – 2598 or gthompson@uecorp.org

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2011-2012 After School Club
Registration Form

Child's Name: _____

Date of Birth: ____/____/____ Age (when school starts): ____

Grade Level: (circle one) (LOWER SCHOOL) Pre K Kindergarten 1st 2nd
(UPPER SCHOOL) 3rd 4th 5th 6th

Parent's Name: 1. _____

2. _____

Street Address: _____

Apt/Unit: _____ City, State & Zip: _____

Home Number: _____ Work: _____

Cell: _____ E mail: _____

Childs Physician: _____

Phone Number: _____ - _____ - _____

Any Medical concerns: _____

Emergency Contacts:

1. Name: _____ #: _____ - _____ - _____ Relationship: _____

2. Name: _____ #: _____ - _____ - _____ Relationship: _____

3. Name: _____ #: _____ - _____ - _____ Relationship: _____

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Authorized Pick Up Persons:

1. Name: _____ #: _____ - _____ - _____ Relationship: _____

2. Name: _____ #: _____ - _____ - _____ Relationship: _____

3. Name: _____ #: _____ - _____ - _____ Relationship: _____

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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.

When parents 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 _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

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

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES

(Initials/Date)

(Initials/Date)

(Initials/Date)

(Initials/Date)

INSTRUCTIONS TO PARENT:

- (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

ALL ABOUT:

Child's First Name or Nickname

Child's Name: _____ Birthdate: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Address: _____ Zip Code: _____

Provider/Center: _____ Phone: _____

Address: _____ Zip Code: _____

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL

WHAT MY CHILD LIKES AND DISLIKES

THINGS I AM WORKING ON WITH MY CHILD

MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES

MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES

MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES

THINGS MY CHILD MIGHT NEED HELP WITH

WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME?

(For the use of the Child Care Facility when needed.)

This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: _____ Date: _____

Provider: _____ Date: _____

Updates:

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Provider: _____

Provider: _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICAL REPORT FOR CHILD CARE

Name of Person being evaluated: _____ Date of Birth: _____

Name of Child Care Applicant/Provider/Facility: _____

Address of Facility: _____

Dear Health Practitioner:

The person to be evaluated either provides (or plans to provide) child care services or lives in a home where family child care is (or will be) given.

1) **RESTRICTED OR REQUIRE SPECIAL CONDITIONS** from contact with children in care due to having any of the following:

a) Communicable disease: _____

b) Chronic medical condition or physical impairment: _____

c) Vision/Hearing/Speech Disorder: _____

d) Nervous or Emotional Disorder: _____

e) Drug or Alcohol Abuse: _____

f) Immunization status: _____

2) Tuberculosis Screening: (if needed or required by the Local Health Officer.)

Type of test: _____ Results: _____ Date: _____

Answer question 3 if the person being evaluated provides (or plans to provide) child care services:

Persons who provide child care services must be able to participate fully in a program for active young children. This includes lifting infants and young children, getting up and down from the floor, lively outdoor activities, and moving furniture. It may also include transporting children in a motor vehicle.

3) Describe medical limitation(s) or medication(s) the person is taking, that may impair the person's ability to perform care-related activities, such as the ones noted above.

Signature of Physician, CNP, RPA

Date

Phone Number

STAMP, PRINT, OR TYPE: Name and Address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____			_____
_____	_____	_____	_____
Name of Parent or Guardian _____			_____
Home Address _____			_____
City _____			State _____ Zip Code _____
Check Best Telephone Number to Reach You:			
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____	<input type="checkbox"/> Cell #: _____	

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

City/Town State Zip Code

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN**

CHILD'S NAME: _____

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (<i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i>)?	_____	_____
2. Does your child have any eye problems (<i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i>)? Date of last eye examination: ____/____/____ Doctor's Name: _____ Results: _____ Does your child wear glasses? _____ Contact lenses? _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
3. Does your child have any ear or hearing problems (<i>frequent earaches, difficulty hearing, etc.</i>)? Date of last hearing evaluation ____/____/____ Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	_____ _____ _____	_____ _____ _____
4. Does your child have any speech problems (<i>difficulty having speech understood, stammering, delayed speech development, etc.</i>)?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: (a) Does this condition require any special health care in the child care facility? (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? (c) Does your child require any special adaptations or adaptive equipment?	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

REMARKS (*Provide further explanation for all "YES" answers*): _____

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: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ___ Positive ___ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS) _____

- a. Vision problem YES NO _____
- b. Hearing problem YES NO _____
- c. Speech or language problem YES NO _____
- d. Other physical illness or impairment YES NO _____
- e. Mental, emotional or behavior problems YES NO _____
- f. Developmental delays YES NO _____
- g. Allergies YES NO _____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO

If YES, please specify: _____

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs? _____

8. Does this child's physical activity need to be restricted? YES NO

If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO

If YES, please specify type: _____

Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a permanent temporary condition until ___/___/____. Check appropriate box, indicate vaccine(s) and reasons: _____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care. (circle correct response)

Signature of Health Practitioner

Date

Phone Number

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE	<u>Baltimore (cont)</u>	<u>Carroll</u>	<u>Frederick(cont)</u>	<u>Montgomery</u>	<u>Prince George's(cont)</u>	<u>St. Mary's</u>
	21210	21155	21783	20783		20606
	21212	21757	21787	20787	20782	20626
	21215	21776	21791	20812	20783	20628
<u>Allegany</u>	21219	21787	21798	20815	20784	20674
ALL	21220	21791		20816	20785	20687
	21221		<u>Garrett</u>	20818	20787	
<u>Anne Arundel</u>	21222	<u>Cecil</u>	ALL	20838	20788	<u>Talbot</u>
20711	21224	21913		20842	20790	21612
20714	21227		<u>Harford</u>	20868	20791	21654
20764	21228	<u>Charles</u>	21001	20877	20792	21657
20779	21229	20640	21010	20901	20799	21665
21060	21234	20658	21034	20910	20912	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237		21078	20913		21676
21226	21239	<u>Dorchester</u>	21082		<u>Queen Anne's</u>	
21402	21244	ALL	21085	<u>Prince George's</u>	21607	<u>Washington</u>
<u>Baltimore</u>	21250		21130	20703	21617	ALL
21027	21251	<u>Frederick</u>	21111	20710	21620	
21052	21282	20842	21160	20712	21623	<u>Wicomico</u>
21071	21286	21701	21161	20722	21628	ALL
21082		21703		20731	21640	
21085	<u>Baltimore City</u>	21704	<u>Howard</u>	20737	21644	<u>Worcester</u>
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	<u>Calvert</u>	21719	<u>Kent</u>	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204		21758	21645	20746		
21206	<u>Caroline</u>	21762	21650	20748	<u>Somerset</u>	
21207	ALL	21769	21651	20752	ALL	
21208		21776	21661	20770		
21209		21778	21667	20781		
		21780				

Parent Provides Information About:

Parents that State-regulated family child care centers must

assume responsibilities as the parent of a child in regulated care, and file a complaint if you believe a care provider has violated licensing regulations.

How is Child Care Regulated?

Child care in Maryland is regulated by the Department of Human Resources (DHR), an agency of the Department of Human Resources. The DHR ensures that safe child care is available to Maryland families.

Child care facilities must meet minimum licensing standards set by Maryland. Licensed facilities must comply with those standards. The DHR inspects by CCA and each year to evaluate the facility's compliance with child care regulations.

Local Offices are responsible for licensing, including:

- care facilities;
- complaints against licensed facilities;
- reports of unlicensed (illegal) child care;
- enforcement action when necessary to ensure compliance with regulations.

Child care is regulated in child care homes and child care centers.

Family Child Care Homes and Child Care Centers Must Meet the Following Requirements:

- Have the approval of CCA, the fire department and other local agencies, as required (i.e., zoning, health, and environment).
- Provide care only in the areas of the facility that have been approved for use.
- Have the license issued by CCA posted where it is easily and clearly visible to parents. The license shows:
 - the maximum number of children who may be present at the same time;
 - the age groups which may be served; and
 - the facility's approved hours of operation.
- At all times, each child must be supervised in a manner appropriate to the child's age, activities, and individual needs.
- All areas of the facility used for child care must be clean, well lit, and properly ventilated. Room temperatures should be comfortable.
- If food service is provided, food must be stored, prepared, and served in a safe, sanitary and healthful manner.
- The facility must offer a daily program of indoor and outdoor activities that are appropriate to the age, needs and capabilities of each child.
- An up-to-date emergency information card must be on file and maintained for each child.
- The facility must post an approved emergency evacuation plan and conduct evacuation drills at least monthly.
- Child discipline procedures must be appropriate to a child's age and maturity level and may not include the deliberate infliction of physical or emotional pain. **Corporal punishment of any kind is strictly prohibited.**



ADDITIONAL INFORMATION

The Maryland Child Care Credentialing Program

Maryland has a voluntary child care credentialing program that recognizes child care providers' education, experience and professional activities at six levels.



Credentialing providers are authorized and encouraged to display the seal issued by the Child Care Administration.

Program Accreditation

Child care programs have the option of becoming state or nationally accredited. Accreditation means that the facility and staff have met program standards of quality.

Child Care and the Americans with Disabilities Act

The federal Americans with Disabilities Act (ADA) requires all child care programs to make reasonable efforts to accommodate children with disabilities. For more information about the ADA, please contact the CCA Regional Office in your area or one of the following organizations:

LOCATE: Child Care

Maryland Committee for Children, Inc.
608 Water Street
Baltimore, MD 21202
Phone: (410) 752-7588
www.mdchildcare.org

Maryland Developmental Disabilities Council

One Market Center
300 West Lexington Street, Box 10
Baltimore, MD 21201
Phone: (410) 333-3688
www.md-council.org



Important Information for Parents of Children in Child Care Facilities



Robert L. Ehrlich, Jr., Governor
Maryland Department of Human Resources
Christopher J. McCabe, Secretary
Equal Opportunity Employer

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