



KD's Klubhouse CDC
 12605 Mattawoman Dr. Waldorf, MD 20601
KdsklubhouseCDC@gmail.com
 Office: (240) 210-8914
 Fax: (240) 607-9236



In case of emergency, when neither parent can be reached, the following should be contacted.

1.) Name:		Relationship:	
Address:		Home Phone:	
		Work Phone:	
2.) Name:		Relationship:	
Address:		Home Phone:	
		Work Phone:	
3.) Name:		Relationship:	
Address:		Home Phone:	
		Work Phone:	
4.) Name:		Relationship:	
Address:		Home Phone:	
		Work Phone:	

Please list the name(s) of person(s) whom you authorize to pick up your child(ren).

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____
- 6.) _____
- 7.) _____
- 8.) _____

You must call first call the center if the person is not on the list.



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Supplies Needed

Date: _____

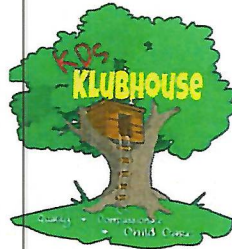
Child's Name: _____

Teacher's Name: _____

The items marked below are not supplied by KD's Klubhouse CDC but they are a must for the proper care of your child(ren) that you need to bring when he/she returns.

- € Pampers/Pull ups
- € Set of changing clothes: T-shirts, socks, pants and shirt (appropriate for the weather)
- € Sheet and blanket to sleep on
- € Wipes

Your child may not return to the Center without them.



Supplies Needed

Date: _____

Child's Name: _____

Teacher's Name: _____

The items marked below are not supplied by KD's Klubhouse CDC but they are a must for the proper care of your child(ren) that you need to bring when he/she returns.

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Late Policy

- Late Arrival

1. Front door will be locked at exactly 9 o'clock in the morning.
2. Late arrival due to medical appointments will be admitted no later than 11:00am with supporting documentation. No proof, no admittance.
3. Parents who call related to late arrival should be forwarded to the office.

Late arrivals will be dealt as follows:

- 1st offense = verbal warning
- 2nd offense = written warning
- 3rd offense = 1 day suspension
- 4th offense = days suspension
- 5th offense = termination

Child Protective Services will be contacted for late pick up after 7 p.m. and a 3-day suspension will be given.

Parent Name

Parent Signature

Date



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Minor Photo or Video Release Form

I give KD's Klubhouse CDC permission to publish in print, electronic, or video format the likeness or image of my child. I release all claims against KD's Klubhouse CDC with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

Minor's name

Parent Name

Parent Signature

Date

General Guidelines: it is recommended that a release form be obtained when photographing or videotaping a minor (under age 18). Parent or guardian signatures are required. This release form is kept on file as your authorization to use your child's photo or video for school purposes only or to share with programs your child's school may participate in for the purpose of highlighting your child's program and your child's participation in the activities of school program.
PHOTOS ARE NOT USED FOR MONETARY PURPOSES ANYTIME.



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Child Care Agreement

Center hours are from 5:30 a.m. to 6 p.m. Monday – Friday

This agreement is for the hours of care that KD's Klubhouse CDC provides for your child(ren). As stated in the Parent Handbook, KD's Klubhouse CDC has a ten (10) hour policy which means that children can only be at the Center ten (10) consecutive hours per day.

Please mark the scheduled time your child(ren) will be arriving and departing the Center.

My child(ren) will be in childcare Monday-Friday between hours of:

5:30 a.m. – 3:30 p.m.
 6 a.m. – 4 p.m.
 7 a.m. – 5 p.m.
 8 a.m. – 6 p.m.

Child's Name: _____

Parent's Name: _____

I understand and agree to follow the schedule I choose on this agreement. I also understand that I need to follow this schedule regardless of when my child arrives at the Center in the morning. For example, if my child has a doctor's appointment and arrives after the beginning time, I checked on this schedule, I must pick up my child up by the ending time I checked on the above schedule. Further, I understand and agree to provide the Director in writing with any changes to the schedule at least two weeks prior to the date I want the change to take effect.

I have read and agree to comply with this agreement.

Parent Signature: _____

Date: _____

Director's Signature: _____

Date: _____



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Toothbrushing Permission Slip

In response to the increasing number of young children with significant dental problems, I plan to institute a toothbrushing program. I hope you will allow your child to participate. Children will learn how to brush their teeth and the importance of doing so. I will supervise the children to assure that the process is sanitary.

Child's Name: _____

_____ Yes, I would like my child to participate in the tooth brushing program.

_____ No, I don't want my child to participate in the tooth brushing program.

If the answer to the question is 'yes', you have more to decide. There is a great deal of evidence that fluoride helps prevent cavities. Therefore, the toothpaste we will be making available to the children will contain fluoride. However, if you decide you do not want your child to use fluoride, he or she may still take part in the toothbrushing program but without using a toothpaste.

_____ My child may use fluoride toothpaste.

_____ My child may not use fluoride toothpaste.

Should you have any questions about the toothbrushing program, please let us know.

Parent/Guardian: _____

Date: _____



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Permission for Education Screening

Dear Parent/ Guardian:

KD'S Klubhouse Child Development Center the Ages and Stages Questionnaire Third Edition (ASQ 3). The tool is designed for early educators and health care professionals. It relies on parents as experts, is easy-to-use, family-friendly and creates the snapshot needed to catch delays *and* celebrate milestones.

To coincide with curriculum-based assessment(s), we monitor each child's achievement of developmental milestones, share observations with parents/guardians, and provide resource information as needed for further screenings, evaluations, and early intervention and treatment. The developmental screening process is a collaborative one, involving parents/guardians and done in conjunction with the child's primary teacher and health, education, and early intervention consultants as needed. Developmental screening is conducted with written consent from the child's parent/guardian(s).

This screening will be conducted within 45 days of your child's first day of care. Please print and sign your name below to provide permission for this screening to be done.

Parent Print Name _____

Child's Name _____

Date of Birth _____

If you do not want to participate in this process, please check the line below;

We do not want to participate in education screening.



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Field Trip Consent Form



My Child _____, has permission to attend all field trips planned by KD'S Klubhouse CDC. I understand that I will be notified in advance that no other signature is needed for permission.

Parent/Guardian: _____
(Print Name)

Parent/Guardian: _____
(Signature)



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HANDBOOK SIGNATURE FORM

Please detach and return this form to the director of KD'S Klubhouse Child Development Center.

I, _____, parent of _____, have read and fully understand the policies and procedure outlined in the Parent's Handbook. I have discussed any policy or procedure I do not understand with the centers. I agree to the policies and procedures that are set forth in this handbook. I will be given an updated copy if any change is made by this center or by the Maryland Department of Education Office of Child Care.

 Child or Children's Name

 Parent's Printed Name

 Child or Children's Name

 Date

Please read this page, sign and return to Director upon child or children's first day of enrollment. Your child will NOT be admitted without the signed Handbook Signature Form.

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 DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE ____/____/____
 COUNTY _____ SCHOOL _____ GRADE _____

PARENT NAME _____ OR
 GUARDIAN ADDRESS _____ PHONE NO. _____
 CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Dose #	Vaccines Type										Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr							
1											1				
2											2				
3												Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4												_____	_____	_____	_____
5												_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
 Signature Title Date
 (Medical provider, local health department official, school official, or child care provider only)

2. _____
 Signature Title Date

3. _____
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

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.

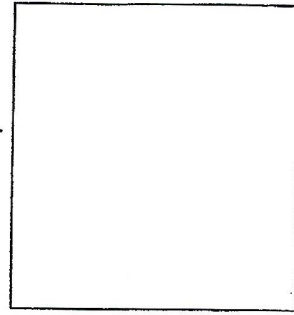
Signed: _____ Date: _____

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM**

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.



Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects & special instructions: _____

Medication shall be administered from: _____ to _____

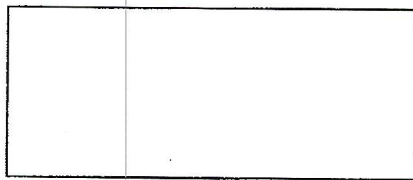
Known Food or Drug: Allergies? Yes No If Yes, please explain _____
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL
(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature Date

Parental approval: _____
Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Health Care Plan Received: YES NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form 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: _____

Maryland State Child Care/Nursery School
 Asthma Medication Administration Authorization Form
 ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)



Triggers (list)

Student's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE				
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency
<input type="checkbox"/> Prior to exercise/sports/ physical education	If using more than twice per week for exercise, notify the health care provider and parent/guardian. (Rescue Medication)			
<input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	Medication	Dose	Route	Frequency
If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.				
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or skin retracts between ribs <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency
Contact the parent/guardian after calling 911.				

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children] Yes No
 Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____
 3/20/2014

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



CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

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

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger: But is <i>not</i> exhibiting or complaining of any symptoms	Give this Medication	
	Epinephrine	Antihistamine
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

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

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

Medication	Dose:
Epinephrine:	
Antihistamine:	
Other:	

Doctor's Signature _____

Date _____

EMERGENCY CALLS

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

Doctor's Name: _____

Phone Number: _____

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

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

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] yes No

Parent/Guardian's Signature _____

Date _____