KD's Klubhouse CDC

12605 Mattawoman Dr. Waldorf, MD 20601
KdsKlubhouseCDC@gmail.com
Office: (240) 210-8914
Fax: (240) 607-9236

Child File Audit Checklist

KD's Klubhouse CDC

- ☐ Permission to Enroll
- ☐ Financial agreement form
- ☐ Registration Form
- ☐ KD's Emergency Form
- ☐ Supplies Needed
- ☐ Late Policy
- ☐ Minor photo/video release form
- ☐ Toothbrushing permission slip
- ☐ Field trip consent form
- ☐ Handbook signature form
- ☐ Child care agreement
- ☐ Permission for educational testing

Maryland License Forms

- ☐ Emergency form
- ☐ Instructions to parents and guardians
- ☐ Health assessment part I and II
- ☐ Health immunization record/shot record
- ☐ Maryland department of health blood lead testing certificate
- ☐ Medication administration authorization form
- ☐ Medication administered
- ☐ Asthma medication administration authorization
- ☐ Allergy action plan
- ☐ Guide to regulated child care

Classroom Assignment: _____ Enrollment Date: _____
Person completing the audit: _____ Date: _____

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PERMISSION TO ENROLL

I am/We are the legal guardian of _____

I am/We are legally authorized to enroll _____ into KD's Klubhouse for child care services.

I/We have a binding court order custody agreement, and I/we will provide a copy of the court order to be placed in _____ file for KD's Klubhouse.

Signature over printed name:

_____

Signature over printed name:

_____

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FINANCIAL AGREEMENT FORM

It has been agreed that _____ will pay $ _____ at the beginning of every week for the care of _____.

Care will be provided _____ days a week between the hours of _____ and _____. An advanced payment of $ _____ will be required and is payable upon enrollment.

Registration fee: $ _____

Enrollment fee: $ _____

I prefer to pay in the following mode(s) of payment:

_____ Cash

_____ Money order

_____ Card (Debit)

_____ Money transfer

_____ CashApp

_____ Zelle

_____ Other

An initial payment of $ _____ was received on _____.

Signature over printed name of enrolling parent:

_____

Received by: _____ Date: _____

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Registration Form

Name: _____
Last First Middle

Date of Birth: _____ Birthplace: _____

SSN: _____ Sex: _____ Home language: _____

Child Lives with: _____
Siblings: _____ _____
_____ _____

Mother's Information

Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Email: _____
Name of Employer: _____
Address: _____
Work Phone: _____

Father's Information

Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Email: _____
Name of Employer: _____
Address: _____
Work Phone: _____

Other important information: _____

New enrollment: ____ yes ____ no

I am a transfer from: _____

Emergency contact person: _____

Emergency contact number: _____

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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.

- € 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.

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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 = 1day 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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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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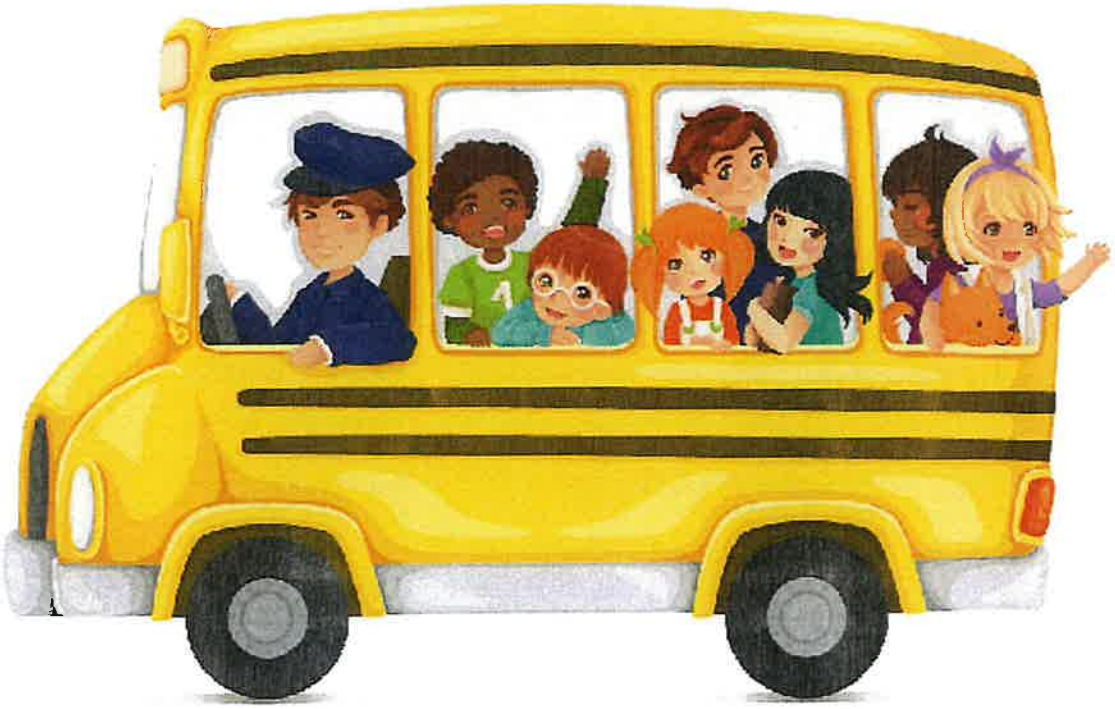
Field Trip Consent Form



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.

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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:

____6:30 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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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.**

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

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

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 IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	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	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/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.

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.

Clinic / Office Name
Office Address/ Phone Number

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 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

OCC 1215 June 2105

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

Child's Picture (Optional)

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.**

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 _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

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 Heath Care Plan Received: ☐ YES ☐ NO

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

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

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

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

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

GREEN ZONE: Long-Term Control Medications — use daily as directed, unless symptoms resolve

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(Rescue Medication)			

☐ Prior to exercise/sports/ physical education

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

Medication	Dose	Route	Frequency

☐ Peak flow between _____ and _____ (50%-79% personal best)

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.

RED ZONE: Emergency Medications — Take these medications and call 911

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other: _____
☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

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)

Place Child's Picture Here

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:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
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

07/18/2023

Parent's Guide to Regulated/ Licensed Child Care

Information About Child Care Facilities

EDUCATION

I_____ the Parents of_____

Have received the Parent's Guide to Regulated/ Licensed Child Care Pamphlet. That identified. Information About Child Care Facilities guide that must be within regulates for questions, concerns to file a complaint. contact the Regional Office.