

**St. Ursula School/Extended Day Program**  
**8900 Harford Road**  
**Baltimore, Maryland 21234**  
**410-665-3533**

June 2026

Dear Parents,

Extended Day is a program offered for before and after care. Listed below is information and guidelines, including the new rates, for this program. In order to have adequate staffing, we are asking all school families who are intending to use Extended Day to register for next year by **June 30, 2026**. Extended Day will begin September 1, 2026. ***If you do not register by June 30th you will not be able to start until September 8th in order to allow adequate time to review all of the necessary paperwork.***

Registration information is attached and may also be found on the school website ([www.stursula.org](http://www.stursula.org)) under the "Academics" tab. Please return all forms via email to the school office at [susoffice@stursula.org](mailto:susoffice@stursula.org) or mail to St. Ursula School, 8900 Harford Road, Baltimore, MD 21234.

Sincerely,  
Emma Riemer  
Extended Day Director

**Hours Of Operation:**

7:00 a.m.- 7:40 a.m.

2:45 p.m. - 6:00 p.m.

**Registration Fees:**

Registration fees are non-refundable

One child	\$25.00
Two children	\$35.00
Three or more children	\$40.00

**Current Fees Beginning August 2025 are as follows:**

**Morning:**

Part Time: \$12. per child per morning

Full Time: \$47.00 per child per week

**Afternoon:**

Part Time: \$24.00 per child per afternoon

Full Time: \$94.00 per child per week

**Both Morning and Afternoon Full Time:**

\$140.00 per child per week

**Registration Requirements:**

The following forms must be returned in order for your child(ren) to start on September 1, 2026. These forms must be completed every year.

- Registration form
- Authorization form
- Emergency form, both pages 1 and 2. This form does not require a doctor's signature. Health Questionnaire
- Health Inventory Part 1. This form does not require a doctor's signature.

The following forms, ***if applicable***, must be returned in order for your child(ren) to start on September 1, 2026. These forms need to be completed every year.

- Allergy and Anaphylaxis Medication Administration Authorization Plan (2 pages)
- Seizure/Convulsion/Epilepsy Disorder Medication Administration Authorization Plan (2 pages)
- Asthma Action Plan (2 pages)

The attached forms are often updated and are the only versions that are permitted by regulation. Any completed forms that are submitted using a prior version will be returned to you and may cause a delay in processing your registration. If you have any questions please contact the school office at [susoffice@stursula.org](mailto:susoffice@stursula.org).

2026-2027

**St. Ursula School Extended  
Day Registration**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

So that we may bill correctly, please check the time(s) that best suit your needs. You may choose a different option for morning and afternoon.

**Morning:**            \_\_\_\_\_ Full Time            \_\_\_\_\_ Part Time

**Afternoon:**        \_\_\_\_\_ Full Time            \_\_\_\_\_ Part Time

Billing is handled as follows:

**Full Time:** You will be billed at the beginning of the month for daily attendance. This option is for parents who will be using Extended Day on a daily basis.

**Part Time:** You will be billed at the end of the month for only the days your child is in attendance. This option is for parents who will not be using Extended Day on a daily basis.

\_\_\_\_\_ I have read the *Guide to Regulated Child Care* that was included with this registration packet.

\_\_\_\_\_ I have received and read the Extended Day Handbook

\_\_\_\_\_ I have paid the registration fee through the provided Pay-It link

Parent's  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**For questions, concerns or to  
file a complaint contact your  
Regional Office**

## Resources

Regional Offices	Phone
Anne Arundel	410-573-9522
Baltimore City	667-354-5178
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worcester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The Regional Offices investigate complaints to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at [CheckCCMD.org](http://CheckCCMD.org).

For additional help, you may contact the  
Director of Licensing at 410-767-0120.

**Child Care Scholarship (CCS)** - Assists eligible parents and families with child care expenses  
**1-877-227-0125** [money4childcare.com](http://money4childcare.com)

**Maryland EXCELS** - Maryland's Quality Rating System for child care programs  
[marylandexcels.org](http://marylandexcels.org)

**Maryland Developmental Disabilities Council** - Assistance with ADA issues [md-council.org](http://md-council.org)

**Maryland Infants and Toddlers Program** - Early intervention services for young children with developmental delays and disabilities and their families [referral.mdip.org](http://referral.mdip.org)

**Maryland Family Network** - Assists parents in locating child care **1-877-261-0060**  
[marylandfamilynetwork.org](http://marylandfamilynetwork.org)

**Maryland Child** - Information about child development, parenting, community resources, mental health, nutrition, literacy, and more.  
[Marylandchild.org](http://Marylandchild.org)

Maryland State Department of Education  
Division of Early Childhood  
200 West Baltimore Street  
10th Floor  
Baltimore, MD 21201  
[earlychildhood.marylandpublicschools.org](http://earlychildhood.marylandpublicschools.org)

**Wes Moore**, Governor

**Carey M. Wright, Ed.D**  
State Superintendent of Schools

# Parent's Guide to Regulated/ Licensed Child Care



## Information About Child Care Facilities

## Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's (OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care;
- Taking enforcement action when necessary; and
- Partnering with community organizations and consumers to keep all children in care safe and healthy.

Regulations governing the Maryland State Department of Education (MSDE) fall under COMAR Title 13A. Regulations that govern child care facilities and other information about the Office of Child Care may be found at:

[earlychildhood.marylandpublicschools.org/child-care-providers/licensing](http://earlychildhood.marylandpublicschools.org/child-care-providers/licensing)

## What are the types of Child Care Facilities?

**Family Child Care** – care in a provider's home for up to eight (8) children with no more than two under the age of two.

**Large Family Child Care** – care in a provider's home for 9-12 children.

**Child Care Center** – non-parental care in a group setting for part of a 24 hour day.

**Letter of Compliance (LOC)** – care in a child care center operated by a religious organization for children who attend their school.

### All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department, and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Must maintain certification in First Aid and CPR;
- Must maintain approved staff and student ratio and provide ACTIVE supervision all times when children are in care;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills, and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury, or injurious treatment.

## Did You Know?

- The provider's license or registration must be posted in a conspicuous place in the facility;

- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;

- Parents/guardians may visit the facility without prior notification any time their children are present;

- Written permission from parents/guardians is required for children to participate in any and all off property activities;

- All child care facilities must make reasonable accommodations for children with special needs;

- A qualified teacher must be assigned to each group of children in a child care center;

- Staff:child ratios must be maintained at all times in child care centers;

- Parents/guardian must be immediately notified if children are injured or have an accident in care;

- Parents/guardians may review the public portion of a licensing file; and

- Check Child Care Maryland, [CheckCCMD.org](http://CheckCCMD.org), is a resource for parents and families to use to review child care provider's license status, verified complaints, compliance history, and inspection results.

# ST. URSULA SCHOOL

2026-27

## EXTENDED DAY HANDBOOK

Revised 06/01/2026

## **Philosophy/Goals**

The Extended Day program is operated under the auspices of St Ursula School, with the same emphasis on children living out their Catholic faith in everyday life. The atmosphere is one of caring and concern while fostering personal and social growth in each child.

The Extended Day program strives to construct an enjoyable atmosphere with varying activities, including vigorous play, art activities, homework time, and indoor play. The children are served a nutritious snack and drink every day.

## **Admission Policies**

Children must be enrolled in St Ursula School to be registered with Extended Day. Extended Day is a privilege, not a right. Parents and students must understand that they must obey the rules and regulations in order to continue in the program.

Registration is held prior to the start of each school year. Any registration received after the due date will be considered late. Students registered after the due date will not be permitted to attend Extended Day until the delayed start date. The due date and delayed start date will be determined prior to the start of registration. In order for students to attend Extended Day, all completed registration forms must be on file. Missing forms or information will delay admission to the program.

## **Billing**

Daily and weekly rates are established prior to the beginning of the school year.

Full time participants will be billed for the current month at the beginning of the month. If school is closed for any reason or your child is absent, you will be billed for the lost time.

Part time participants are billed at the beginning of the following month for days in attendance the prior month.

Plan choice options are determined by the parent/guardian. If you wish to change your plan, it must be submitted in writing.

Billing is processed through your FACTS account monthly. Invoices must be paid by the 20<sup>th</sup> of the month. **FAILURE TO PAY IN FULL BY THE 20<sup>TH</sup> OF THE MONTH MAY RESULT IN SUSPENSION FROM THE PROGRAM UNTIL FULL PAYMENT IS RECEIVED.**

## **Hours of Operation**

Morning                7:00-7:40 a.m.

Afternoon            2:45-6:00 p.m.

Extended Day closes at 6:00 PM under normal circumstances. This includes scheduled early dismissal days. Anyone picking up late will be charged a fee of \$1.00 per minute *per child*. Late fees are not billable. Fees are due at pick-up time. If the fee is not paid at pick-up, an invoice will be issued. Failure to pay a late fee invoice within 20 days will result in suspension from the program until paid in full.

### **Inclement Weather, Late Opening or Early Dismissal**

Saint Ursula School and Extended Day follows the Baltimore County Public School decision on these days including cancellation of all after school activities. You will receive notification from our school email system regarding any school cancellations, or postponements. **If Baltimore County Schools are previously scheduled to be closed on an inclement weather day you will receive a message regarding any cancellations or postponements for Saint Ursula School.**

For those attending Extended Day, the following procedures are in effect:

- If school opens 1 hour late, Extended Day opens at 8am.
- If school opens 2 hours late, Extended Day opens at 9am.
- If school closes 1 or 2 hours early, Extended Day closes at 4pm.
- If school closes 3 hours early, Extended Day closes at 3:00 pm.
- If BCPS after school activities are canceled, Extended Day **closes at 4 pm.**

Anyone registered with Extended Day is welcome to utilize the morning or afternoon program in the event of late opening or early dismissal.

### **Communication**

Parents may not engage any of the Extended Day workers or students in conference or communication. Concerns should be brought to the attention of the Director of the program.

If your child attends Extended Day, please do not email daily changes to Extended Day. Instead, please email any changes to the school office and/or the teacher. Extended Day staff are not in the building during the school day.

Parents may not communicate with their child while they are in attendance at Extended Day. Use of cell phones by students is not permitted while they are in attendance.

### **Morning Drop Off**

Morning Extended Day is held in the lunchroom. Drop off is at the first set of doors on Manns Avenue (doors closest to Harford Road to the left of the doors used to enter the school office). Drop off begins at and NOT BEFORE 7:00 AM. Parents are welcome to walk their child(ren) into the building as far as the interior doors. Parents may not enter the lunchroom at drop off time.

There is no food service/consumption of food or drink during morning Extended Day. Please have your child eat breakfast before arriving in the morning.

Morning Extended Day ends promptly at 7:40 AM. Any students arriving after 7:40 AM must enter the building using the Neifeld Avenue entrance and following the morning drop off procedures. Students may not be dropped off at the school office during morning arrival (7:40-8:10).

### **Afternoon Pick Up**

An Authorization Form and an Emergency Form are required as part of the registration packet. Any person listed on either form will be permitted to pick up your student. Photo identification will be requested for verification. If a question arises, a phone call will be made to confirm pick up arrangements. Please make sure the information on all forms is complete and current. Children may not leave until they are signed out. Any changes in normal pick up arrangements must be submitted in writing.

Pick-up is held in the lunchroom. Parents may not enter the lunchroom during pick up. After signing out your child(ren), please wait in the hallway. Please do not enter the two classrooms located in this hallway.

### **Attendance**

Attendance is taken as the students arrive at Extended Day. Students must come directly to Extended Day directly from their classrooms, unless they are attending an afterschool activity. Students attending an afterschool activity are marked in attendance once the activity ends and they arrive at Extended Day.

Once students are signed out of Extended Day or dismissed from school, they may not return until the following school day.

### **After School Activities**

Students who are enrolled in afterschool activities are dismissed from their homerooms directly to that activity. After the activity ends, students that arrive at Extended Day are given a snack and must work on their assigned homework.

We do not escort students outside of the school building for any afterschool activities. Arrangements for escort must be made by parents for any activity held anywhere other than in the school building.

## Daily Schedule

Normally, Extended Day operates on the following schedule Monday-Thursday. This may change due to special events, early closure due to inclement weather, or other unplanned events.

2:45-3:15 All students arrive and are served a snack and drink

---

3:15-4:15 Students in PreK through grade 3 go outside

Students in grades 4-8 inside for homework

4:15-5:00 Students in grades 1-3 inside for homework

Students in grades 4-8 go outside

Students in grades PreK and Kindergarten have play time from 3:10-5:00 Mon-Fri

There is no homework time on Fridays or, if school is closed on Friday, the last school day of the week. Students have play time from 3:30 -5:00.

Daily, at 5:00 all remaining students are gathered in the lunchroom.

This schedule is subject to change without notice.

On occasion we do show movies, have organized games, crafts, dancing, make use of the Wii, etc. Students remain with their assigned group during these activities.

## Food Service

Students are provided a healthy snack and drink daily upon arrival at afternoon Extended Day. Our snack schedule is posted in the lunchroom. ***Students may bring additional healthy snacks and drinks to Extended Day. Please do not send soda or food that requires refrigeration.***

There is no food service **during** morning Extended Day. Students must eat breakfast prior to arrival.

## Food Allergies

If your child has a documented food allergy, please supply an afterschool snack. Please send the healthy snack in your child's lunchbox.

## Homework

Students in grades 1-8 work independently on homework. They are supervised in a group setting monitored by staff members. If the students ask for help or have questions, we offer assistance. We do not check homework for accuracy or completion. Students must bring all books and materials needed to complete their assignments. Homework time is not an option. All students are expected to participate, have their own supplies, work quietly, and have a book

to read in the event that they finish early. Students may not return to their classrooms for any reason after dismissal.

## **Playtime**

All students have play time daily. We DO go outside daily. Please have your student dressed appropriately, especially for the cold weather. Hats, scarves, and gloves are encouraged. Girls may wear sweatpants, pajama pants or leggings in addition to their jumper during Extended Day.

## **Uniform**

Students must stay in their school uniform during Extended Day. They may change into tennis shoes upon arrival. It is the student's responsibility to remember to do so and secure their uniform shoes. We are not responsible if a student forgets to change shoes or loses shoes. Students may not change out of their uniform until after they are signed out for the day.

## **Health**

If a student presents with an illness during Extended Day that warrants exclusion, the parents/guardian will be contacted. These illnesses include, but are not limited to: vomiting, fever, and diarrhea. If we are not able to contact a parent/guardian, we will contact an adult listed as authorized to pick up the student. The Health Room is notified when students are sent home due to illness. We do not contact parents/guardians for minor cuts, bruises, injuries or bathroom "accidents". Parents are notified at pick up time of minor incidents. The school nurse is not on duty during Extended Day hours.

## **Health/Medication Forms**

If your child has a documented medical condition and/or requires medication during Extended Day, please notify the program directors. Extended Day must have completed Medication Administration forms on file to administer any medications. These are not the forms used by the school's Health Room. The forms may be found on the school's website. All prescribed medications must be in the original container from the pharmacy with the pharmacy label attached. Over the counter medication must be in the packaging clearly marked with the student's name.

## **Discipline**

Any student who consistently misbehaves, is non-cooperative, or fails to comply with the stated rules will receive a demerit. This must be signed by both the student and a parent/guardian and returned within 2 days.

Three demerits will result in a 3 day suspension from the program to be determined by school administration.

Time outs are used for younger students and are age appropriate. Students being uncooperative or argumentative during any activity will be removed from the activity for a brief period to regroup. The student will be given another opportunity to participate. If after two attempts are made and the problem continues, the student will be redirected to another activity.

## **General Rules**

---

1. Each child is expected to participate in all activities.
2. No child is to leave a supervised area without expressed adult permission.
3. No foul language, profanity, inappropriate conduct or disrespectful behavior will be tolerated.
4. As stated in the school handbook, items such as toys, games, cell phones, personal electronic devices, radios, CD's or other articles from home are inappropriate in school and Extended Day and may not be used in Extended Day.
5. On occasion movies will be shown to the students. Selected movies are rated G or PG.
6. On occasion students will be permitted to play the Wii in a group setting.
7. All policies listed in the Student/Parent handbook also apply during Extend Day.
8. Students and parents may not go to the classrooms for any reason during Extended Day hours. Please do not ask any staff members for permission to do so.

Extended Day follows all policies listed in the Student/Parent Handbook

## **EXTENDED DAY ADMINISTRATION**

**Director:** Emma Riemer ([eriemer@stursula.org](mailto:eriemer@stursula.org))

**EXTENDED DAY PHONE NUMBER:** 410-665-7036

(Only available from 7:00-7:40 am and from 2:30-6:00 pm.)

**SAINT URSULA EXTENDED DAY  
AUTHORIZATION FORM**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

The following people are authorized to sign out my child(ren) from Saint Ursula Extended Day Program. Please have the person(s) listed below bring a photo ID. Please include all parents/guardians.

1. Parent/Guardian (please print) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

2. Parent/Guardian (please print) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

List below others who are eligible for pick-up other than parent/guardian

\* \* \* \* \*

3. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

4. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

5. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

6. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

**EXTENDED DAY HEALTH QUESTIONNAIRE  
2026-2027**

**\*\*Please complete one form in full for each child being registered.**

Student Name and Grade: \_\_\_\_\_

Parent Contact Information: \_\_\_\_\_

Mother: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Father: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

1. Does your child have any medical conditions, including food allergies, which should be brought to our attention: (FOOD ALLERGIES MUST BE LISTED UNDER #2)

No \_\_\_\_\_

Yes \_\_\_\_\_ (If yes, please complete #2)

2. If yes, please list below information regarding your child's condition. An Extended Day staff member will contact you to follow up regarding treatment, medication, additional required paperwork, etc. If additional space is needed, please continue on a separate sheet of paper.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CACFP Enrollment: Yes:  No:

Meals your child will receive while in care:

BK  LN  SU  AM Snk  PM Snk  Evng Snk

**EMERGENCY FORM**

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
			C:	W:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) \_\_\_\_\_  
 Last First Relationship to Child

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

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES**

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

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

1. Name \_\_\_\_\_ 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: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address: _____			Mo / Day / Yr		
_____	_____	_____	_____	_____	_____
Number	Street	Apt#	City	State	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W:	C:	H:	
		W:	C:	H:	
<b>Medical Care Provider</b> Name: Address: Phone:	<b>Health Care Specialist</b> Name: Address: Phone:	<b>Dental Care Provider</b> Name: Address: Phone:	<b>Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child Care Scholarship</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Last Time Child Seen for Physical Exam:</b> <b>Dental Care Specialist:</b>	
<b>ASSESSMENT OF CHILD'S HEALTH</b> - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
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.					
Printed Name and Signature of Parent/Guardian _____					Date _____

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

Place Child's Picture Here (optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
Page 1 to be completed by the Authorized Health Care Provider.  
**FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216**

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of plan: \_\_\_\_\_  
 Child has Allergy to: \_\_\_\_\_  Ingestion/Mouth  Inhalation  Skin Contact  Sting  Other: \_\_\_\_\_  
 Child has had anaphylaxis:  Yes  No  
 Child has asthma:  Yes  No (If yes, higher chance severe reaction) Child  
 may self-carry medication:  Yes  No  
 Child may self-administer medication:  Yes  No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
<b>Is Not exhibiting or complaining of any symptoms, OR</b>		
<b>Exhibits or complains of any symptoms below:</b>		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Throat*:</b> difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
<b>Lung*:</b> shortness of breath, repetitive coughing, wheezing		
<b>Heart*:</b> weak or fast pulse, low blood pressure, fainting, pale, blueness		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Other:</b>		
<b>If reaction is progressing (several of the above areas affected)</b>		

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

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) Inject epinephrine right away! Note time when epinephrine was administered.
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE	Place stamp here		
TELEPHONE	FAX		
ADDRESS			

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

Maryland State Department of Education  
Office of Child Care  
**Allergy and Anaphylaxis**  
**Medication Administration Authorization Plan**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE (mm/dd/yyyy) \_\_\_\_\_ INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION \_\_\_\_\_

CELL PHONE # \_\_\_\_\_ HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

**Section IV: CHILD CARE STAFF USE ONLY**

Child Care Responsibilities:	1. Medication named above was received	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. OCC 1214 Emergency Card updated	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	6. Individualized Plan: IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	7. Staff approved to administer medication is available onsite field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed by: (printed name and signature): \_\_\_\_\_ DATE (mm/dd/yyyy) \_\_\_\_\_

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last) \_\_\_\_\_ 2. DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. Child's picture (optional)

**Section 1. ASTHMA ACTION PLAN - MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

4. ASTHMA SEVERITY:  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise Induced  Peak Flow Best \_\_\_\_ %

5. ASTHMA TRIGGERS (check all that apply):  Colds  URI  Seasonal Allergies  Pollen  Exercise  Animals  Dust  Smoke  Food  Weather  Other \_\_\_\_\_

6. This authorization is NOT TO EXCEED 1 YEAR FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

FOR ASTHMA MEDICATION ONLY - THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer  Yes  No

**GREEN ZONE - DOING WELL - Long Term Control Medication - Use Daily At Home unless otherwise indicated**

The Child has ALL of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good				
<input type="checkbox"/> No cough or wheeze				
<input type="checkbox"/> Can walk, exercise, & play				
<input type="checkbox"/> Can sleep all night				
<input type="checkbox"/> If known, peak flow greater than ____ (80% personal best)				

**Exercise Zone**  CALL 911  CALL PARENT  OTHER

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports				
<input type="checkbox"/> When the child feels they need it				

**YELLOW ZONE - GETTING WORSE**  CALL 911  CALL PARENT  OTHER

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing				
<input type="checkbox"/> Wheezing, noisy breathing				
<input type="checkbox"/> Tight chest				
<input type="checkbox"/> Cough or cold symptoms				
<input type="checkbox"/> Shortness of breath				
<input type="checkbox"/> Other: _____				

The Child has ANY of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast				
<input type="checkbox"/> Lips or fingernails are blue				
<input type="checkbox"/> Trouble walking or talking				
<input type="checkbox"/> Medication is not helping (15-20 mins?)				
<input type="checkbox"/> Other: _____				
<input type="checkbox"/> If known, peak flow below ____ (10% to 49% personal best)				

**RED ZONE - MEDICAL ALERT/DANGER**  CALL 911  CALL PARENT  OTHER

The Child has ANY of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast				
<input type="checkbox"/> Lips or fingernails are blue				
<input type="checkbox"/> Trouble walking or talking				
<input type="checkbox"/> Medication is not helping (15-20 mins?)				
<input type="checkbox"/> Other: _____				
<input type="checkbox"/> If known, peak flow below ____ (10% to 49% personal best)				



**MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure/Convulsion/Epilepsy Disorder  
Medication Administration Authorization Form**

Place Child's  
Picture Here  
(Optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
**Page 1 is to be completed by the authorized Health Care Provider.**  
**FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216**

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Plan: \_\_\_\_\_

Significant Medical/Health History: \_\_\_\_\_

Seizure Triggers or Warning Signs: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Seizure Care Information**

Seizure Type	Length (duration)	Frequency	Description

- Seizure Emergency Protocol:** How to respond to a seizure (Check all that apply)
- First Aid – Stay. Safe. Side (refer to resource document "Seizure First Aid Guide")
- Call 911 for transport to \_\_\_\_\_  Notify parent or emergency contact
- Notify Health Care Provider \_\_\_\_\_  Other \_\_\_\_\_

Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

**Care after seizure:** Does the child need to leave the classroom after a seizure?  Yes  No

What type of help is needed? (describe) \_\_\_\_\_

When can the child return to care/resume regular activity? \_\_\_\_\_

Special Considerations and Precautions (regarding activities, sports, trips, etc.) \_\_\_\_\_

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)

**MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure/Convulsion/Epilepsy Disorder  
Medication Administration Authorization Form**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I authorize the child care staff to administer the medication as prescribed above. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #		WORK PHONE #
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

**CHILD CARE STAFF USE ONLY**

Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Medication labeled as required by COMAR <input type="checkbox"/> Yes <input type="checkbox"/> No 3. OCC 1214 Emergency Form updated <input type="checkbox"/> Yes <input type="checkbox"/> No 4. OCC 1215 Health Inventory updated <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Staff has received additional training to administer the medication. If Yes: Trainer Name and Title _____ Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Modified Diet/Exercise Plan <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 8. Individualized Treatment/Care Plan Medical/Behavioral/IEP/IFSP <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
------------------------------	---	--

Reviewed by (printed name and signature): _____	DATE (mm/dd/yyyy) _____
---	-------------------------

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE

Maryland State Department of Education  
Office of Child Care  
**Medication Administration Authorization Form**

Place Child's  
Picture Here  
(optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. This authorization is **NOT TO EXCEED 1 YEAR**.  
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications. Prescription medication must be in a container labeled by the pharmacist or prescriber.  
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

**PRESCRIBER'S AUTHORIZATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If PRN, for what symptoms, how often and how long \_\_\_\_\_

Possible side effects and special instructions: \_\_\_\_\_

Known Food or Drug Allergies:  Yes  No If yes, please explain: \_\_\_\_\_

For School Age children only: The child may self-carry this medication:  Yes  No

The child may self-administer this medication:  Yes  No

PRESCRIBER'S NAME/TITLE	Place Stamp Here (Optional)
TELEPHONE	FAX
ADDRESS	

**PRESCRIBER'S SIGNATURE** (Parent/guardian cannot sign here) (original signature or signature stamp only) **DATE** (mm/dd/yyyy)

**PARENT/GUARDIAN AUTHORIZATION**

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer**  Yes  No

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

**CHILD CARE STAFF USE ONLY**

Child Care Responsibility:	1. Medication named above was received. Expiration date <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Medication labeled as required by COMAR <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. OCC 1214 Emergency Form updated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	4. OCC 1215 Health Inventory updated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	5. Individualized Treatment/Care Plan: Medical/Behavioral/EP/IFSP <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	6. Staff approved to administer medication is available onsite, field trips <input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed by (printed name and signature): _____	DATE (mm/dd/yyyy) _____
---	-------------------------