

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

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

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

Evidence of Blood-Lead Testing for children living in designated at risk areas. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at <http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Last First Middle			Mo / Day / Yr			
Address: _____						
Number Street		Apt# City		State		Zip
Parent/Guardian Name(s)		Relationship		Phone Number(s)		
		W: _____		C: _____		H: _____
		W: _____		C: _____		H: _____
Your Child's Routine Medical Care Provider			Your Child's Routine Dental Care Provider			Last Time Child Seen for
Name: _____			Name: _____			Physical Exam:
Address: _____			Address: _____			Dental Care:
Phone # _____			Phone _____			Any Specialist :
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.						
	Yes	No	Comments (required for any Yes answer)			
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>				
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>				
Asthma or Breathing	<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"/>				
Coughing	<input type="checkbox"/>	<input type="checkbox"/>				
Communication	<input type="checkbox"/>	<input type="checkbox"/>				
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>				
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>				
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>				
Feeding	<input type="checkbox"/>	<input type="checkbox"/>				
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>				
Heart	<input type="checkbox"/>	<input type="checkbox"/>				
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>				
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>				
Life Threatening Allergic 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"/>				
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>				
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>				
Surgery	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>				
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?						
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____						
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulln, Counseling etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____						
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> 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:	Birth Date:	Sex
Last First Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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_dhmv_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		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1 Test#2	Test # 1 Test #2

_____ has had a complete physical examination and any concerns have been noted above.
(Child's Name)

Additional Comments: _____

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

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

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

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

PARENT OR GUARDIAN _____ / _____ / _____
 LAST FIRST MIDDLE

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

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

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

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

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

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

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

Comments:

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

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

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

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

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

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

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

Lead Risk Assessment Questionnaire Screening Questions:

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

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

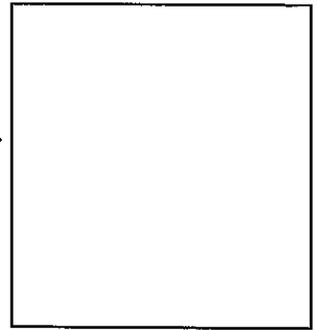
Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

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: _____

Telephone: _____ (Type or print) 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 STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure Medication Administration Authorization Form**

Name of Child Care Facility _____

This form authorizes emergency seizure care for _____ M F

(Child's Name)

(Date of Birth)

while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician _____ Phone# _____ # After Hours _____

Significant Medical History: _____

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Seizure Emergency Protocol (Check all that apply and clarify below)

- Call 911 for transport to _____ Notify parent or emergency contact
 Notify treating physician _____ Other _____

Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure? Yes No If YES, describe process for returning the child to the classroom. _____

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

Physician Signature: _____ Date: _____

Parent Information & Authorization: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

Parent/Guardian Signature: _____ Date: _____

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:	Give this Medication	
	Epinephrine	Antihistamine
But is <i>not</i> 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.

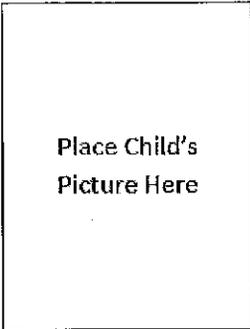
Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] yes No

Parent/Guardian's Signature

Date

Allergy Action Plan (Continued)

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



CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

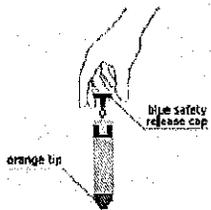
Is the child Asthmatic? No Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

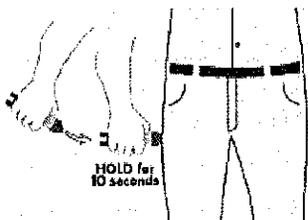
- Reduce exposure to allergen(s) by: (no sharing food, _____)
- Ensure proper hand washing procedures are followed. _____
- Observe and monitor child for any signs of allergic reaction(s). _____
- Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) _____
- Ensure that a person trained in Medication Administration accompanies child on any off-site activity. _____
- _____



userguide



1 Pull off the blue safety release cap.



2 Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.

Please note: As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine. Which you inject into your outer thigh. DO NOT INJECT INTRAVENOUSLY. DO NOT INJECT INTO YOUR BUTTOCK. As this may not be effective in a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.

Call 911

3 Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

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 EpiPen®, EpiPen 2-Ph®, and EpiPen & 2-Ph® are registered trademarks of Mylan Inc. Licensed exclusively to its wholly-owned subsidiary, Day Pharma, LP.

The Parent/Guardian will:

- Ensure the child care facility has a sufficient supply of emergency medication.
- Replace medication prior to the expiration date
- Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- _____

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

Breathing is good
 No cough or wheeze
 Can work, exercise, play
 Other: _____
 Peak flow greater than _____ (50% personal best)

Prior to exercise/sports/ physical education

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

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)

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

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.

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: _____

For questions, concerns or to file a complaint contact your regional office

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
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 OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

Resources

Child Care Subsidy - Assists parents with cost of childcare

1-866-243-8796

Consumer Product Safety Commission (CPSC) - regulates certain products used in childcare

cpsc.org

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org



Larry Hogan, Governor

Karen B. Salmon, Ph.D.

State Superintendent of Schools

OCC 1524 (10/2018)

Guide to Regulated Child Care



Important

Information

About Child

Care Facilities

Who Regulates Child Care?

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; and
 - Taking enforcement action when necessary.
- For more information about the regulations, visit the Office of Child Care website at:

<http://www.earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care>



What are the types of Child Care Facilities?

Family Child Care – care in a provider's home for up to eight (8) children

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

Child Care Center – non-residential care

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;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- 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?

- Regulations that govern child care facilities may be found at: www.earlychildhood.marylandpublicschools.org/regulations
- 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 "Teacher" qualified person 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;
- Child care facilities may have policies beyond regulatory requirements;
- OCC should be notified if a provider has violated child care regulations;
- Parents/guardians may review the public portion of licensing file; and
- The provider's compliance history may be reviewed on [CheckCCMD.org](http://www.CheckCCMD.org).