All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

Enrollment Checklist

___ Health Inventory Part 1 (completed by parent)
___ Health Inventory Part 2 (completed/signed by doctor)
___ Immunization Records
___ Lead Screening (completed at age 1 and 2)
___ Emergency Card
___ Parent Handbook form
___ Enrollment Agreement
___ Photo/Video Waiver
___ IEP form (if needed)
___ Food Program application
___ DDA Gym Permission form

Enrollment Supplies

Infant Rooms

- Diapers
- Wipes
- 2 sets of weather appropriate clothing
- 2 crib sheets
- Bottles for every feeding (pre-made, pre-powdered, or pre-watered. NO GLASS. Must be fresh bottle for every feeding) If breast feeding, only enough for the day please.
- Pacifier, if needed.
- Sippy cup, in needed.
- AACLC supplies bibs daily

Toddler Room

- Diapers/ Pullups
- Wipes
- 2 sets of weather appropriate clothing, including shoes
- 2 crib sheets
- Sippy cup

Twos, Threes, and Fours

- Cot supplies- cot sheet, blanket, pillow (optional)
- Drawstring bag to keep cot supplies together
- 2 sets of weather appropriate clothing, including shoes
- 1 box of tissues
- Diapers/ Pullups and wipes, if not toilet trained

Medication forms are needed for any diaper cream, sunscreen or medications. These forms are available in the office if needed. A Doctor does not need to sign a form for diaper cream unless treating a rash or for sunscreen. If there are any allergies or asthma issues, please inform teachers. There are additional forms needed for children with these conditions.

PLEASE LABEL EVERYTHING!!!

AACLC School Closing Days

2020

Labor Day	September 7
Thanksgiving	November 26, 27
Christmas	December 24, 25
New Years Eve	Close at 3

2021

New Years Day	January 1
Good Friday	April 2
Memorial Day	May 31
Independence Day	July 5
School Prep Days	August 26,27
Labor Day	September 6
Thanksgiving	November 25,26
Christmas	December 24, 27
New Years Eve	Close at 3
New Years Day	January 1, 2022

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

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**
Last First Middle Mo / Day / Yr 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 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

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)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
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.

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.

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

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

CACFP Enrollment : Yes:_____No:_____
Days & Hours : Mon___Tues__Wed__Thurs___Friday___

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

All About Children Learning Center
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Baltimore, MD 21227
410-242-6009

Tuition Cost for Enrollment

I, _____, enroll my child _____

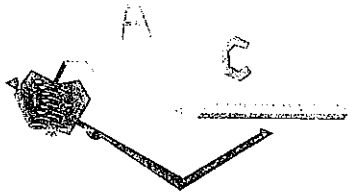
for full/ part time care: Monday Tuesday Wednesday Thursday Friday. (please circle days). We plan to attend from the hours of _____ to _____. The fee for this weekly tuition will be $_____ per week paid on Fridays the week before care is provided. I agree to give 2 weeks notification if/when I decide to leave AACLC. I understand if I do not give proper notification I can be charged up to 2 weeks tuition. I also understand that all holidays, sick days, closings and any other days must still be paid with tuition. After one year of enrollment I may receive one week half priced tuition for vacation, all 5 days in one week.

_____ _____

Parent Signature Date

_____

Director Signature



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I/We, _____, parent/legal guardian of _____ acknowledge we have viewed a copy of All About Children Learning Center's parent handbook as posted on the company's website. (arbutuspreschool.com) and agree to all the terms provided within the handbook. I/We understand the polices described are not conditions of enrollment and does not create a contract for care. AACLC reserves the right to alter, amend, or modify guidelines with written notice given to parents in advance.

_____ _____

Signature Signature

_____ _____

Printed name Printed name

Release and Consent Form
For the use of recorded materials, image, sound, videotape, film, photograph, CD, or audiotape.

I hereby authorize All About Children Learning Center and its affiliates, employees and assigns to use the subject's name, voice, likeness and/or picture (still or motion) for use in advertising, promotion, reproduction, or broadcast of said project. Furthermore, I hereby release All About Children Learning Center and its affiliates, employees and assigns from all liabilities in connection with the use of the aforementioned project materials.

I agree that, All About Children Learning Center, and any designates shall have the right to use the Film/Video/Print/Audio/Media produced hereunder at any time, as frequently as desired and in any place.

I acknowledge that I am over the age of eighteen and authorize All About Children Learning Center and its designates to use in any manner whatsoever and without restriction any recorded Film/Video/Print/Audio/Media of the subject or property belonging to the subject, any statements or recordings of the subject's voice made by the subject, or any use of the subject's name during the process for any purpose and without restriction.

Project Title: All About Children Learning Center Web Site

Name of Subject /Minor_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email_____

I, _____ as the Subject, or Father, Mother, or Guardian of the Minor named

_____as "subject," do consent to the release of the material described above.

Signature_____

Print Name_____ Relationship to Subject_____

IEP Information for New Families

AACLC would like the opportunity to help all the children in our care in any way that we can. We offer connections to many programs to help the whole child on different levels. If your child is currently in need of support, we may be able to help. If your child is already in a program and have an IFSP/IEP, please know that we are here to help your family in any way we can. We encourage you to have program providers come to visit your child in our setting and to have our teachers involved as much as they are able. If your child has a current IEP/IFSP please submit to us upon enrollment. Please return this form if any of the following applies to your child:

_____ I would like information for programs for my child

_____ I currently have an IEP/IFSP for my child.

Optional:

- Workers name and contact information_____
- Home School Location _____
- Weekly visit dates and times_____

We would like to work as a team in any way possible to provide the best care for your child. Submitting any information regarding your child's IEP/IFSP is completely optional, but helps us to provide proper accommodations, if necessary. Thank you in advance and we look forward to serving your family.

Heather Kuchta

Director of AACLC

All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

Cot Permission Form

I, _____, give permission for my child, _____ who is under two, to sleep on a cot at All About Children Learning Center. I will provide the appropriate bedding for my child. Children under 1 are not permitted to use pillows.

_____ _____

Parent Signature Date

Individualized Infant Care Plan

Child's Name: _____ DOB/Age: _____

Enrollment Date: _____ Days & Hours of Attendance: _____

Allergies/Medical Conditions: _____

Breast Milk or Formula- Brand of Formula: _____

Heated by: _____

Eating Schedule/Preferences:

_____

_____

Napping Schedule/Preferences:

_____

_____

Diapering Preferences:

_____

Activity Schedule (Includes twice daily outside time):

_____

_____

Likes/Dislikes:

_____

Special Needs/Instructions:

_____

Primary Staff Member Name Printed: Signature and Date:

_____

_____

Parent(s) Name Printed: Signature(s) and Date:

_____

_____

PO Box 9643
Baltimore, MD 21237
410-419-6802
kristin@kcdanceandfitness.com
www.kcdanceandfitness.com

Jump N' Move

All About Children Learning Center

Today's Date_____

Student's Name_____ **Age** _____

Date of Birth_____

Parent's Name(s):_____

Address_____ **City/State**_____**Zip Code**_____

Cell Phone_____

E-mail_____

LIABILITY WAIVER

1. I understand that dance and fitness may require strenuous physical activity and that there is a risk of personal injury or other losses or damages arising out of such.
2. I certify that the student is physically fit and has no physical or mental condition, which may limit his or her ability to safely participate in the classes in which the student has enrolled, and/ or else I am willing to assume, and bear the costs of all risks that may be created, directly or indirectly, by any such condition.
3. I hereby acknowledge and agree that, by participating in the dance and/or fitness programs offered, I assume all of the risk of injury, and I hereby agree further that I will not assert any claim against KC DANCE & FITNESS LLC or its employees by reason of any injury, or other losses or damages arising out of the student's participation in the dance recitals.
4. I hereby voluntarily release, and agree to indemnify and hold harmless KC DANCE & FITNESS LLC and its employees from any and all claims, demands, or causes of action, which are in any way connected with the student's participation in the dance and/or fitness classes or recitals and any and all liability for any injuries or illnesses sustained or incurred while participating in the program at KC DANCE & FITNESS LLC or during any activity organized by KC DANCE & FITNESS LLC.
5. Should KC DANCE & FITNESS LLC, or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.
6. I hereby authorize the staff members at KC DANCE & FITNESS LLC to act for the student in any emergency requiring medical attention using their best judgment.
7. All medical expenses incurred will be the responsibility of the student or the student's family. I have no knowledge of any physical or mental impairment or disability that would prevent the student's participation in this program.
8. The student is covered exclusively by medical and other health insurance and I am responsible for all medical payments.

Photography Release

KC Dance & Fitness LLC may occasionally use (except where prohibited by law) the students name, photograph, and any statement or remark the student or his or her parent has made about participating in our programs or recitals for advertising and promotional purposes without additional compensation. Unless otherwise notified in writing, I give permission for KC Dance & Fitness LLC to use the student's photographs, name or statements.

Parent Signature: _____

Printed Name: _____Date: _____

The Planning Council & MSDE Form

INFANT FEEDING PLAN (For children 0 - 12 mos.)

Center Name: AACLC

Address: 1201 Maple Ave Arbutus, MD 21227

Dear Parent(s)/Legal Guardian(s):

This center/provider offers Parents Choice Standard iron-fortified infant formula
Formula name
for all enrolled infants at no additional charge. It is your option whether or not to use this formula based on your preference and your infant's needs. All formula that is provided to infants at this facility must be iron-fortified as required by the Child and Adult Care Food Program.

PARENT FORMULA REQUEST

Please check one of the following options, **regarding FORMULA:**

_____I will provide expressed breast milk for my infant. I understand that the breast milk I supply must be labeled with my child's name and the date the milk was expressed.

_____I will use the infant formula offered by this facility.

_____I ***will not*** use the infant formula offered by the facility. I will supply the following Infant formula for my infant _____.
Formula name

I understand that I must supply sufficient infant formula each day to meet my child's needs. Bottles must be labeled with my child's name and be dated. Bottles must be taken home daily.

PARENT FOOD REQUEST

When your infant is developmentally ready to eat solid foods, do you accept or decline the provider/facility-supplied food?

Please check one of the following options, **regarding FOODS:**

_____I will supply all supplemental foods for my infant. [*Center may not claim my child for meals*]

_____I will **ACCEPT** the supplemental foods offered to my infant(s) by this facility.

Child's Name: _____

Child's Date of Birth: _____

_____ _____
Signature of Parent/Legal Guardian Date

All food and beverages served to infants in this facility must be in compliance with the infant meal pattern required by the Child and Adult Care Food Program.

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed or approved private homes.
- **After School Care Programs**: Centers in low-income areas provide free snacks to School-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

AACLC
1201 Maple Ave.
Arbutus, MD 21227

Nondiscrimination

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Women, Infants, and Children (WIC) Nutrition Program

Better Nutrition for A Brighter Future

About

WIC is a federally funded program that provides healthy supplemental foods and nutrition counseling for pregnant women, new mothers, infants, and children under age five.

WIC Works Wonders

For Women
Women in the WIC Program eat better and have healthier babies.

For Infants
Infants born to WIC mothers weigh more and grow and develop better.

For Children
Children on WIC eat foods with more iron and vitamin C, which helps them develop strong minds and bodies.

Who is Eligible

- Live in Maryland.
- Are pregnant, a new mother, an infant or child under 5 years of age.
- Have a nutritional need.
- Have a household gross (before taxes and deductions) income that is less than or equal to the income guidelines below, or you receive benefits from the Food Supplement Program, Medical Assistance, Temporary Cash Assistance or participate in the Maryland Children's Health Program.

Household Size	Year	Month	Twice Per Month	Every Two Weeks	Week
1	$22,459	$1,872	$936	$864	$432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,768	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member add . . .	$7,992	$666	$333	$308	$154

● www.mdwic.org ● 800-242-4942 ● email to: dhmh.wic@maryland.gov

08/18

ENROLLMENT FOR CHILD AND ADULT CARE FOOD PROGRAM

New: _____ Renewal: _____ [*Sponsor Only: ____ PD ____ Free ____ Red. ____ Incomplete*]

Name of Child Care Center:	All About Children Learning Center

Important: This form must be updated annually.

Name(s) of Enrolled Children: (Please print)	Days in Care (Check days that apply)							Meals Served (Check meals that apply)				
	M	TU	WE	TH	FR	SA	SU	Breakfast	AM Snack	Lunch	PM Snack	Supper
1. DOB: _____ Time In: ____ Out: ____ Class: _____												
2. DOB: _____ Time In: ____ Out: ____ Class: _____												
3. DOB: _____ Time In: ____ Out: ____ Class: _____												
4. DOB: _____ Time In: ____ Out: ____ Class: _____												
5. DOB: _____ Time In: ____ Out: ____ Class: _____												

_____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian

_____

Date Signed

Phone Number of Parent/Guardian: _____

The Planning Council & MSDE Form

INFANT FEEDING PLAN (For children 0 - 12 mos.)

Center Name: All About Children Learning Center

Address: 1201 Maple Avenue

Dear Parent(s)/Legal Guardian(s):

This center/provider offers _____ iron-fortified infant formula
Formula name

for all enrolled infants at no additional charge. It is your option whether or not to use this formula based on your preference and your infant's needs. All formula that is provided to infants at this facility must be iron-fortified as required by the Child and Adult Care Food Program.

PARENT FORMULA REQUEST

Please check one of the following options, **regarding FORMULA:**

_____I will provide expressed breast milk for my infant. I understand that the breast milk I supply must be labeled with my child's name and the date the milk was expressed.

_____I will use the infant formula offered by this facility.

_____I ***will not*** use the infant formula offered by the facility. I will supply the following Infant formula for my infant _____.
Formula name

I understand that I must supply sufficient infant formula each day to meet my child's needs. Bottles must be labeled with my child's name and be dated. Bottles must be taken home daily.

PARENT FOOD REQUEST

When your infant is developmentally ready to eat solid foods, do you accept or decline the provider/facility-supplied food?

Please check one of the following options, **regarding FOODS:**

_____I will supply all supplemental foods for my infant. [*Center may not claim my child for meals*]

_____I will **ACCEPT** the supplemental foods offered to my infant(s) by this facility.

Child's Name: _____

Child's Date of Birth: _____

_____ _____
Signature of Parent/Legal Guardian Date

All food and beverages served to infants in this facility must be in compliance with the infant meal pattern required by the Child and Adult Care Food Program.

Meal Benefit Application for Child Care Centers

July 01, 2020 - June 30, 2021

For more information, read **Instructions for Completing** or call: (855) 427-2888

Step 1 | **List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).**

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 | **Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? Circle One: Yes No**

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: | | | | | | | | |

Step 3 | **Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)**

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): | |

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: | | | |

Check if No SSN: ☐

Step 4 | **Contact Information and Adult Signature**

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 | **OPTIONAL: Children's Racial and Ethnic Identities**

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ _____

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: _____ Date: _____

Date Withdrawn: _____

INSTRUCTIONS FOR COMPLETING MEAL BENEFIT APPLICATION - Child Care Center

Complete the application using the instructions below. Sign the form and return it to the center. If you need help, call (855) 427-2888

STEP 1 - CHILDREN'S INFORMATION - ALL HOUSEHOLDS COMPLETE

List the first and last name of all enrolled children. Indicate if a foster child, homeless, migrant, runaway, or in Head Start, Early Head Start or Even Start by checking the box. If ALL children listed are foster, homeless, migrant, runaway, or in Head Start, Early Head Start, or Even Start, skip to Step 4.

STEP 2 - CASE NUMBER

If any member of your household receives benefits from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA), write the case number and skip to Step 4.

STEP 3 - NAMES OF ALL HOUSEHOLD MEMBERS AND GROSS INCOME

- List the first and last name of everyone in your household, whether they receive income or not. Your household includes all those living as one economic unit. Include yourself, all children living with you, including foster children and any other person living in your household, related or not. List each type of income received last month and how often it is received. You must indicate how much in whole dollars, and how often received (weekly, bi-weekly, twice a month, monthly, yearly). **If a household member has no income-write '0' in the income box.**
- Report all income as gross income. Gross income is the amount earned before taxes and other deductions. This is not the same as take- home pay. Gross income includes unemployment benefits, Worker's Compensation, Supplemental Security Income and Veteran's benefits, Social Security, private pensions or disability, strike benefits, income from trusts or estates, annuities, investment income earned interest, rental income and regular cash payments from outside household. For self-owned business, farm, or rental income, report income as **net income**.
- If you are in the Military Housing Privatization Initiative, do not include your housing allowance as income. Do not include combat pay.
- Indicate the total number of household members in the space provided.
  - The form must have the last four digits of the Social Security Number of the primary wage earner or adult who signs unless the adult does not have a Social Security Number. If the adult does not have a Social Security Number, check the box. The last four digits of the Social Security Number are not needed if you listed a FSP or TCA case number, or if you are only applying for foster children.

STEP 4 - SIGNATURE - ALL HOUSEHOLDS COMPLETE

All forms must have the signature of an adult household member.

STEP 5 - RACIAL/ETHNIC IDENTITY

You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.

Federal Income Guidelines

Household Size	Year	Month	Week
1	$23,606	$1,968	$454
2	31,894	2,658	614
3	40,182	3,349	773
4	48,470	4,040	933
5	56,758	4,730	1,092
6	65,046	5,421	1,251
7	73,334	6,112	1,411
8	81,622	6,802	1,570
For each additional family member add	$8,288	$691	$160

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you are only applying for foster children, or you list a Food Supplement Program or Temporary Cash Assistance case number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine