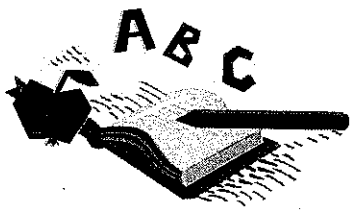


All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009
aaclcltd@gmail.com

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

AACLC SCHOOL CLOSING DATES

2026

Good Friday	April 3
Memorial Day	May 25
Independence Day	July 3
School Prep Days	August 20/21
Labor Day	September 7
Thanksgiving	November 26/27
Christmas	December 24/25
New Years Eve	December 31, close at 12

2027

New Years Day	January 1
Good Friday	March 26
Memorial Day	May 31
Independence Day	July 5
School Prep Days	August 19/20
Labor Day	September 6
Thanksgiving	November 25/26
Christmas	December 24/27
New Years	Dec 30, close at 12, closed Dec 31

Enrollment Supplies

Infant Rooms

- Diapers and wipes (a case/time for FT and sleeve/time for part time is ok)
- 3 sets of weather appropriate clothing. Bibs, if needed. Shoe size bin w/lid.
- 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.
- Drawstring/reusable bag on Mondays and Fridays

Toddler Room

- Diapers and wipes(a case/time for FT and sleeve/time for part time is ok)
- 3 sets of weather appropriate clothing and shoes in shoe size bin w/ lid
- 2 crib sheets
- 2 Sippy cups per day

Twos, Threes, and Fours

- Cot supplies- cot sheet, blanket, pillow (optional)
- Drawstring/reusable bag to keep cot supplies together
- 2 sets of weather appropriate clothing and shoes in shoe size bin w/ lid
- 1 box of tissues
- Diapers/ Pullups and wipes, if not toilet trained
- Reusable water cup/bottle

Threes and Fours only: Plastic Pencil Box, pencils, 8 crayons, 12 colored pencils, plastic pocket folder, dull tip scissors, glue sticks, dry erase markers, 8 washable markers

Medication forms are needed for ALL 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 illness policy

AACLC does its best every day to ensure a safe and healthy environment for all children in our care. We understand that illnesses do happen and we want to outline our guidelines for diagnosis and returning to the center. At times, AACLC may need to override a Doctors return to center if we have an "outbreak" (2 or more in a 7 day period) of certain illnesses to help contain the spread. We have to remember that children put their hands in their mouths, cough/sneeze without covering their mouths, rub their eyes, etc and many of our illnesses are spread that way. We do our best to keep our classrooms clean, but we need the assistance from parents to keep everyone healthy by making the best decision for their child and the others in their room. AACLC will send children home if they have a fever (100.4 for children under 1 and 101.0 for children over 1), more than 2 diarrhea in 1 hour, vomiting 2 times or more in one day, excessive coughing or a combination of multiple symptoms of a potential illness. You are required to arrive within an hour of notice that your child will need to be picked up. If you cannot, please call someone else closer that can make it. Below are our most common illnesses and our current policy for each one.

Fever- may return after 24 hours fever free, without fever reducing medication (this is for ANY other illness as well)

Pink eye- 2 rounds of drops should be administered before returning

Hand, foot and mouth- 24 hours fever free (without medication), no blisters that are not popped, all blisters should be scabbed over

RSV- 24 hours fever free (without medication), minimal coughing, no wheezing

Covid- 10 days out from positive test date. If parents are positive and child is not child should stay home for 5 days and be retested. Most children seem to catch it later on since they do not have anyone else to care for them at home.

Vomiting/diarrhea- sent home if more than 2 times in a day (vomiting) or 2 times in one hour (diarrhea). Can return the next day, but if one case occurs at the center they will have to go home again. Should pass one normal BM before returning.

Strep throat- 24 hours fever free (without medication), antibiotics given for 12 hours

Flu- 24 hours fever free (without medication), symptom free

We understand that it can become inconvenient to miss time from work with a sick child, but we must think of all the other children and teachers that are in the front-line taking care of all of the children every day. We do our best to make the best decision while the children in our care. We are not doctors but have experienced children with some of these illnesses. It takes a village to raise a child, and we are glad that you chose AACLC to be part of your village.

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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations**. The immunization certification form (MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old.** The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at:https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620.
- **Medication Administration Authorization Forms.** If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: https://health.maryland.gov/Pages/Home.aspx#

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program

PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
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:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance / Child Care Scholarship	Last Time Child Seen for
Name: Address: Phone:	Name: Address: Phone:	Name: Address: Phone:	☐ Yes ☐ No Child Care Scholarship ☐ Yes ☐ No	Physical Exam: Dental Care: 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	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ 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

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Health Care Provider

Child's Name: Last	First	Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

2. Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

3. 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:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. 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).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. Should there be any restriction of physical activity in child care?
☐ No ☐ Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 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: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

10. **RECORD OF LEAD TESTING** - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4								
5	DOSE #5												

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

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

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

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

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: _____ Date: _____

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND STATE DEPARTMENT OF EDUCATION - Office of Child Care

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: H:	W: Employer:
		Email:	C: H:	W: 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 _____

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete.*

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
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

I/we, _____, the parent/legal guardian of _____ acknowledge that we have viewed a copy of All About Children Learning Center's parent handbook that is posted on the company's website (arbutuspreschool.com) and agree to all the terms provided within the handbook. I/we understand the policies described are not conditions of enrollment and does not create a contract for care. AACLC reserved the right to alter, amend or modify guidelines with written notice to parents in advance. I also acknowledge that I have received a copy of the MD Infants and Toddler program's informational pamphlet within this new enrollment packet.

_____ _____

Signature Signature

_____ _____

Printed name Printed name

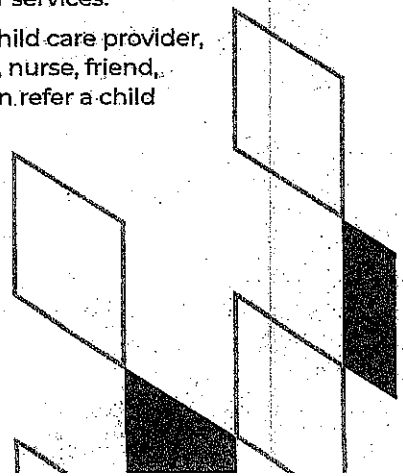
WORRIED ABOUT A BABY OR TODDLER YOU KNOW?

- Does your child have trouble participating in everyday activities like eating, dressing, and playing?
- Do you wonder if your granddaughter should be talking more?
- Does a toddler in your child care program hit, kick, bite, and cry more than you expect for children their age?
- Has your baby received a medical diagnosis that affects their growth and learning?

The Maryland Infants and Toddlers Program (MITP) can help!

MITP provides free, family-centered support for children from birth to age three. Children with medical conditions that can impact their development in the future may be eligible to receive support now. Children who are not moving, communicating, learning, interacting with others, or participating in daily activities like others of the same age may also be eligible, even if they don't have a diagnosis. A free assessment of the child's development is provided to determine if they are eligible for services.

Anyone – a parent, child care provider, doctor, grandparent, nurse, friend, or other relative – can refer a child to MITP.



Anyone can submit a referral to the Maryland Infants and Toddlers Program.
If the child lives in Maryland and hasn't turned three yet, MITP can help.

referral.mditp.org
1-800-535-0182

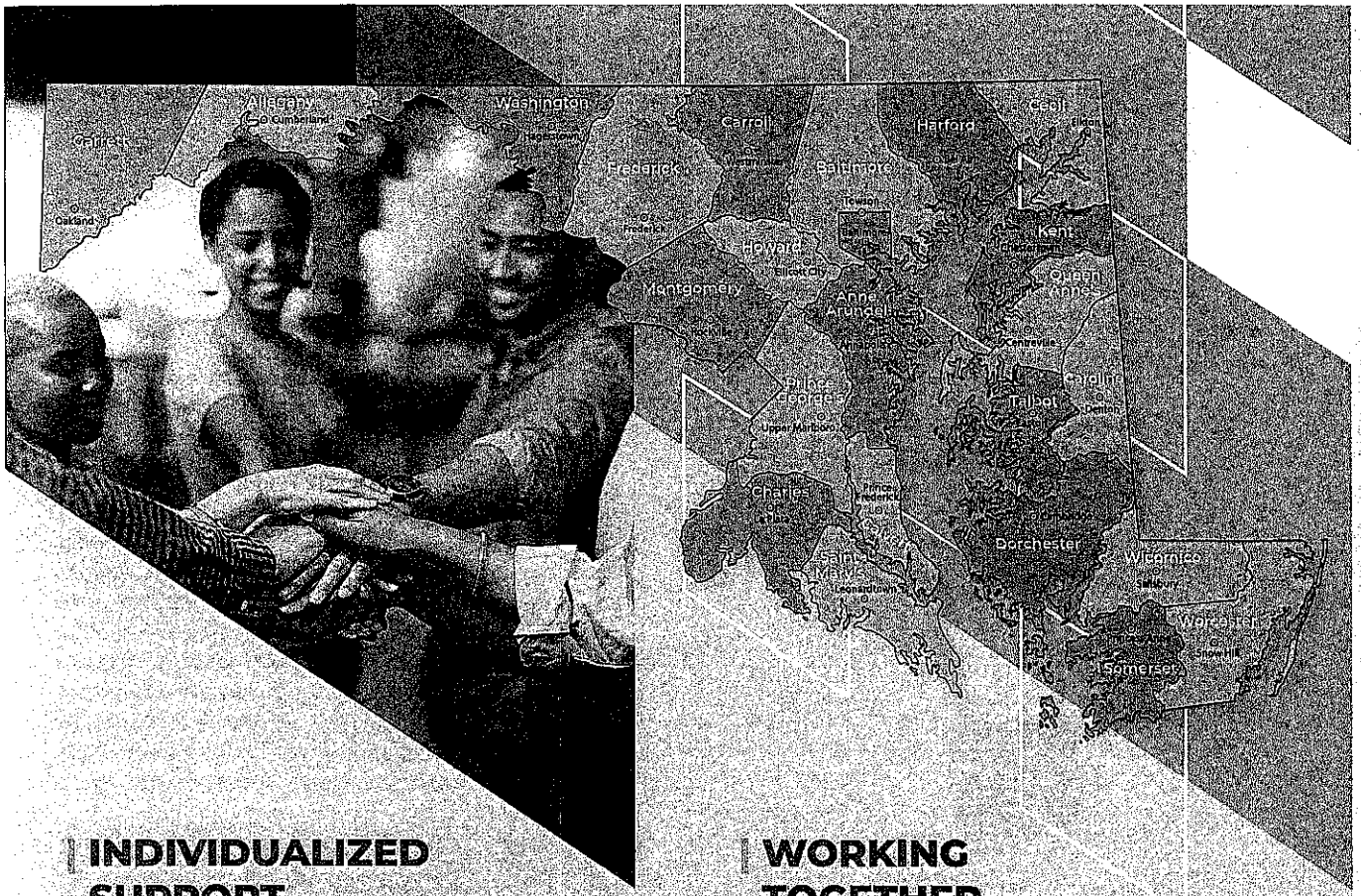
Maryland
STATE DEPARTMENT OF EDUCATION

WE BEGIN EARLY TO FINISH STRONG

Maryland Infants and Toddlers Program

Supporting young children with developmental delays and disabilities and their families

Maryland
STATE DEPARTMENT OF EDUCATION



INDIVIDUALIZED SUPPORT

The Maryland Infants and Toddlers Program (MITP) is here to help you help your child grow and learn. Infants and Toddlers Program services will:

- Build on your child's and family's strengths
- Address your goals and concerns in a way that works for your family
- Help you learn about your child's needs and the resources available to your family

The teachers, therapists, and other providers will come to you at home, at child care, at the library, or other places your family spends time. They will coach and support you to help your child participate and develop new skills. They will connect you with other resources in the community.

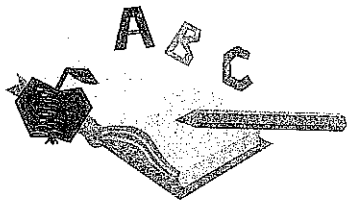
WORKING TOGETHER

Helping babies and toddlers develop to their maximum potential is a team effort! Families are the key to their children's growth and learning. Physicians, child care providers, nurses, social workers, and other people who work with children are also important.

Anyone who works with or knows a child and has concerns can submit a referral to the Maryland Infants and Toddlers Program. Child care providers are also required by State law to provide information to families each year about Early Intervention and to help families schedule evaluations.

NEXT STEPS

1. Visit referral.mditp.org to learn more information and to complete an online referral. You can also call 1-800-535-0182 to get contact information for your local Infants and Toddlers Program. You can make the referral over the phone if you prefer.
2. After the referral, someone from the local Infants and Toddlers program will call you. You will share information about your child's development and any concerns. An appointment for a developmental screening or evaluation will be scheduled.
3. The evaluation will take place in your home or another location if you prefer. The team will ask you questions about your child and observe how they move, communicate, and play.
4. If your child is eligible for services, you will become a part of the early intervention team. Together you will develop a plan. **All evaluations and services are provided free of charge! You give your permission for all assessments and services, and you can stop or change services at any time.**



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

All About Children Learning Center
1201 Maple Ave
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

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_____

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:

_____

_____

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

Child and Adult Care Food Program

Center Name: All About Children Learning Center

Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/ or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period . Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child (ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		A.M.	P.M.	TIME	A.M.	P.M.	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
LAST NAME	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours									
BIRTH DATE	Other:									
AGE	**Enrollment Date:** **Withdrawal Date:**									

Signature

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY:

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) ***mail: U.S. Department of Agriculture***
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) ***fax: (202) 690-7442; or***

(3) ***email: program.intake@usda.gov***

This institution is an equal opportunity provider.

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, 2026 - June 30, 2027

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: _____

Center Name: All About Children Learning Center