

# Essential Personnel Child Care Family Enrollment Application 2020

MARYLAND STATE DEPARTMENT OF EDUCATION

Parent or Guardian must qualify as essential personnel under the Governor's Executive Order.

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

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

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

## Home Contact Information:

Type of Essential Personnel \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

## Work Contact Information:

Name of Agency: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Best way to contact you during work hours: \_\_\_\_\_

## Parent/Guardian Information:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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

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

Company Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Company Phone: \_\_\_\_\_

Company Phone: \_\_\_\_\_

# Essential Personnel Child Care Family Enrollment Application

2020

## MARYLAND STATE DEPARTMENT OF EDUCATION

Days of Child Care Service Desired (check all that apply):

MON \_\_\_\_\_ TUE \_\_\_\_\_ WED \_\_\_\_\_ THU \_\_\_\_\_ FRI \_\_\_\_\_

Hours of Child Care Service Desired (check all that apply):

MON \_\_\_\_\_ TUE \_\_\_\_\_ WED \_\_\_\_\_ THU \_\_\_\_\_ FRI \_\_\_\_\_

Please initial the following.

\_\_\_\_ I agree to have the temperature taken of my child(ren) arriving at the building with a temporal thermometer.

\_\_\_\_ I agree to remove my child from care if a fever is identified upon arrival to site.

\_\_\_\_ I agree to limit contact by limiting inside access and will drop off and pick up my child at the door.

\_\_\_\_ I agree to practice social distancing the best way possible, within the setting.

\_\_\_\_ I agree that the facility is not charging me any additional fees or tuition for my child(ren).

\_\_\_\_ I agree to be charged the full tuition rate charged by this program if I am found to not qualify for the State of Maryland EPSA/EPCC programs by not being essential personnel under Governor Larry Hogan's Executive Order.

*I hereby agree to abide by the terms and conditions as provided in this Emergency Personnel School Age (EPSA) Child Care/ Essential Personnel Child Care (EPCC) Programs Family Enrollment Application. At least one parent/guardian of the child(ren) is designated essential personnel. I understand that any violation of the aforesaid terms and conditions may result in termination of enrollment of my child(ren).*

Parent/Guardian Name (Please Print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / 2020

Facility Director/ Designee Name (Please Print): \_\_\_\_\_

Facility Director/ Designee Name Signature \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / 2020

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

**HEALTH HISTORY FORM**  
For Use in Drop-In Child Care Centers\*

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

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Check the correct answers to the following questions. Give a brief explanation under COMMENTS for any YES answer.

Does the child have any of the following?	YES	NO	COMMENTS
a) Vision problem?			
b) Hearing problem?			
c) Speech or language problem?			
d) Physical illness or impairment problem?			
e) Mental, emotional or behavioral problem?			
f) Developmental delay?			
g) Allergies?			
h) Other? <i>(If YES, specify)</i>			
i) Health condition which may require care or emergency action? <i>(If YES, specify, e.g. seizures, bee sting allergy, diabetes, etc.) Attach plan for addressing incidents should they arise.</i>			
j) Does the child have up-to-date immunizations?			
k) Is the child currently taking any medication?			

This child is otherwise in good physical and mental health. This child is also free of communicable disease and may participate fully in all activities.

YES	NO

List any areas of the program in which the child cannot fully participate. Would any limits or alterations help to meet his or her needs? Please explain briefly.

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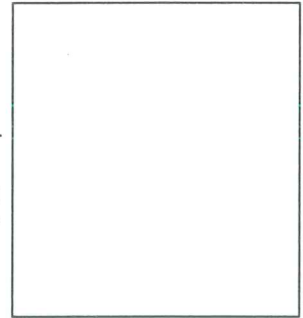
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Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

\* A parent may object when medical examination of a child conflicts with the parent's bona fide religious belief and practice. Under such circumstances, the parent may also use this form.

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)

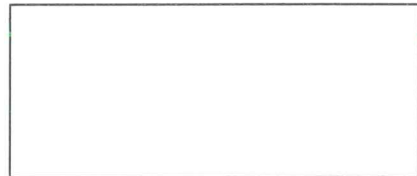
Prescriber's Name/Title: \_\_\_\_\_

(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: \_\_\_\_\_  
Signature Date

Parental approval: \_\_\_\_\_  
Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received:  YES  NO

Medication was received by: \_\_\_\_\_  
Signature of Person Receiving Medication and Reviewing the Form Date





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: \_\_\_\_\_  
\_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_