



Parent Handbook Available Online

www.kidsafterhours.com

I have read and understand the Parent's Guide to Regulated Childcare. I give MCPS/SHS permission to release medical records to Kids After Hours. I give Kids After Hours permission to transport my child on all field trips by bus or passenger van. I hereby consent to the use of my child's likeness to be photographed and/or videotaped by Kids After Hours, Inc. to use on the internet web pages and promotional materials. Children's names, home addresses, and telephone numbers will never be used. I give Kids After Hours permission to apply CVS Brand Sunscreen to my camper during the Summer months.

I HAVE READ THE KIDS AFTER HOURS PARENT HANDBOOK. I UNDERSTAND AND AGREE TO COMPLY WITH THE POLICIES AND PROCEDURES OF KIDS AFTER HOURS, INC.

The Kids After Hours Parent Handbook can be downloaded from our website www.kidsafterhours.com or can be provided by your Center's Director. This page must be signed and returned to your Center's Director prior to your child's first day of care.

CHILD'S NAME _____

PARENT'S SIGNATURE _____ DATE _____

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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.
- **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://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.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://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div>			Mo / Day / Yr			
Number _____ Street _____ Apt# _____ City _____ State _____ Zip _____						
Parent/Guardian Name(s)		Relationship		Phone Number(s)		
		W: _____		C: _____		H: _____
		W: _____		C: _____		H: _____
Where do you usually take your child for routine medical care? Name: _____						
Address: _____				Phone Number: _____		
When was the last time your child had a physical exam? Month: _____ Year: _____						
Where do you usually take your child for dental care? Name: _____						
Address: _____				Phone Number: _____		
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.						
	Yes	No	Comments (required for any Yes answer)			
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>				
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>				
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>				
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>				
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>				
Bladder	<input type="checkbox"/>	<input type="checkbox"/>				
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>				
Bowels	<input type="checkbox"/>	<input type="checkbox"/>				
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>				
Coughing	<input type="checkbox"/>	<input type="checkbox"/>				
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>				
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>				
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>				
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>				
Heart	<input type="checkbox"/>	<input type="checkbox"/>				
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>				
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>				
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>				
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>				
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>				
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>				
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>				
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>				
Surgery	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>				
Does your child take medication (prescription or non-prescription) at any time?						
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____						
Does your child receive any special treatments? (nebulizer, epi-pen, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____						
Does your child require any special procedures? (catheterization, G-Tube, etc.)						
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____						
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.						
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.						
Signature of Parent/Guardian _____						Date _____

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: _____	C: _____	H: _____
		W: _____		
		Place of Employment: _____	C: _____	H: _____
		W: _____		

Name of Person Authorized to Pick Up Child (*daily*) _____
Last First Relationship to Child

Address	City	State	Zip Code
Street/Apt.#			

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 _____