



**OUR COMPLETE 2016-2017
FREE PRE-K ENROLLMENT PACKET**

Themba Creative Learning Center, LLC
2016 -2017 Prekindergarten Program Registration Application Check list
Themba Will Only Accept Completed Applications

Student Name_____

Date of Birth_____

*** Child must be four by September 1 ***

<u>Item Required</u>	<u>Available</u>	<u>Not Available</u>
✓ Birth Certificate	_____	_____
✓ Completed Enrollment Package for website: thembaclc.com	_____	_____
✓ Proof of Income: Review carefully all documents submitted.	_____	_____
✓ 2015 Tax Returns	_____	_____
✓ Unemployment Stubs/Letter	_____	_____
✓ TCA/Cash Assistance	_____	_____
✓ Notarized Salary letter on Company Letterhead	_____	_____
✓ W2/1040	_____	_____
✓ Shot Records	_____	_____
✓ Health Records	_____	_____
✓ Copy of a Valid Driver's License	_____	_____

Application Submitted By _____ Date_____

Application Reviewed By _____ Date_____

2016 Federal Poverty Level Chart*

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the “federal poverty level” (FPL). Federally-facilitated Marketplaces will use the 2016 guidelines when making calculations for the insurance affordability programs starting November 1, 2015.

Household Size	100%	138%	150%	200%	250%	300%	400%
1	\$11,770	\$16,242	\$17,655	\$23,540	\$29,425	\$35,310	\$47,080
2	\$15,930	\$21,983	\$23,895	\$31,860	\$39,825	\$47,790	\$63,720
3	\$20,090	\$27,724	\$30,135	\$40,180	\$50,225	\$60,270	\$80,360
4	\$24,250	\$33,465	\$36,375	\$48,500	\$60,625	\$72,750	\$97,000
5	\$28,410	\$39,205	\$42,615	\$56,820	\$71,025	\$85,230	\$113,640
6	\$32,570	\$44,946	\$48,855	\$65,140	\$81,425	\$97,710	\$130,280
7	\$36,730	\$50,687	\$55,095	\$73,460	\$91,825	\$110,190	\$146,920
8	\$40,890	\$56,428	\$61,335	\$81,780	\$102,225	\$122,670	\$163,360

*Chart is for 48 contiguous states and the District of Columbia; for Hawaii and Alaska please visit the website of the HHS Assistant Secretary for Planning and Evaluation (ASPE): <http://aspe.hhs.gov/poverty/14poverty.cfm>.

**Dollar amounts are calculated based on 100% column; rounding rules may vary across federal, state, and local programs.

Every year, the perimeters of the Federal Poverty Level (FPL) increase based on the cost of living. Families need to understand where they fall on the FPL so they know whether they are eligible for Medicaid in their state or whether they are eligible for a federal subsidy because they earn between 100 and 400 percent of the FPL, or whether they are eligible for a tax credit because they purchased a Silver plan and earn less than 250 percent of the FPL.

To qualify for Cost-Sharing, one must be enrolled in a Silver level plan through a Marketplace

Cost-sharing reductions are not available for coverage purchased outside of the Marketplace.

Individuals and families with household incomes generally up to 250% of the FPL may be eligible to receive cost-sharing reductions. Household income is determined by calculating a consumer's modified adjusted gross income (MAGI). Members of federally recognized tribes may qualify for additional cost-sharing benefits.

Cost-sharing Reductions Calculations Table

Reduction in Maximum Annual Limitation on Cost Sharing for 2016

Plan Variation (from 70% AV Silver Plan)	Income Range for Individual*	Individual Out-of- Pocket Maximum (standard 2016 limit: \$6,850)	Income Range for Family of Three*	Family Out-of-Pocket Maximum (standard 2016 limit: \$13,700)
94% AV Silver Plan Variation (for households with a MAGI between 100-150% of FPL)	\$11,770- \$17,655	\$2,250	\$20,090- \$30,135	\$4,500
87% AV Silver Plan Variation (for households with a MAGI between 150-200% of FPL)	\$17,655- \$23,540	\$2,250	\$30,135- \$40,180	\$4,500
73% AV Silver Plan Variation (for households with a MAGI between 200-250% of FPL)	\$23,540- \$29,425	\$5,200	\$40,180- \$50,225	\$10,400

American Indians/Alaska Natives with MAGI below 300% of FPL enrolled in a zero cost sharing plan variation have all cost sharing eliminated for EHB. American Indians/Alaska Natives with MAGI above 300% of FPL enrolled in a limited cost sharing plan variation have cost sharing eliminated for any EHB item or service that is furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

*Please review the 2015 Federal Poverty Chart in the Resources tab to find dollar ranges for the different percentages of FPL. These figures are higher in Alaska and Hawaii.



6715 Cipriano Road, Lanham- Maryland 20706
Center: 301-552-5437 | Fax: 301-552-7565 fax www.thembacdc.com

New Parent Orientation Check List

- ☐ Tour of Facility
- ☐ Introduction to teaching staff
- ☐ Parent visit with the classroom teacher
- ☐ Receipt of parent handbook (download from website)
- ☐ Discussion of expectations of family and the needs of the child
- ☐ Overview of family support resource and activities
- ☐ Interpreter available if needed
- ☐ Agree to the potty training routine for our two yr. olds

Parent Signature _____ Date _____

Child's Name _____ Age _____

Parent/Guardian Acknowledgement
Of
Receipt of Parent Manual

I have received Themba Creative Learning Center LLC, **Parent Manual** and I have agreed to read, abide by, and follow the policies set forth therein.

Children Transport to and from evacuation sites in case of emergency:

In case of an emergency, I give Themba permission to transport my child in personal vehicles to and from our designated evacuation site. I therefore acknowledge that I have received and read Themba's Emergency Preparedness Plan.

Yes___ No___

If no, how would you like your child transported?

Additionally, I would like to volunteer by helping with transporting children to the evaluation site during emergencies.

Yes___

No___

If yes, kindly provide us with your best reachable contact number

() - | (type) Cell___ Home___ Work___

Email Address _____

Signature of Parent(s)/Guardian(s)

Print Name

Date



Please label all of your child's belongings. THIS IS A MUST!!



Three/Four Year Old Supply List

- 2-3 sets of clothing please include underclothes
- 1 small blanket and 2 crib sheets
- 2 boxes of **large** Crayons and crayon box
- 1 paint smock or over sized shirt
- 1 small picture of your child and family members
- 2 boxes of tissues
- Closed toe shoes only no flip flops
- Glue sticks
- Large Beginners Pencils (Ticonderoga)
- 1 pair of Child Scissors
- 2 folders –2 composition notebooks
- 1 pack of facial wipes
- 1 pack of flushable wipes
- Reusable Water Bottle
- Pull ups if child isn't potty trained



**Please label all of your child's belongings.
THIS IS A MUST!!**

Before & After Care Supply List

- 2 Boxes of tissues
- 2 Folders
- 2-composition notebooks
- 1 Small picture of your child and family members
- Closed toe shoes only no flip-flops
- A Reusable Water Bottle
- Crayon box
- **NO GLASS BOTTLES OR CONTAINERS**

Mandatory Themba Uniform Policy

Ages 2-4yrs | Monday-Friday

- **Navy blue Khaki dress, skirt, or bottoms (no jeans)**
- **Navy blue sweater (optional)**
- **Powder blue or white collared top (no tee shirts)**
- **Closed toe shoes only ****

If your child is not in uniform, you will be asked to pick your child up or bring the uniform to the center in a timely manner.

Children do not wear uniforms during the summer months

Themba Creative Learning Center LLC. ENROLLMENT AGREEMENT

TO THE PARENT: Please read this Agreement carefully. If you do not understand any part of it, feel free to ask the Center Director about it. This Agreement and its attachments establish your legal rights and responsibilities, and those of **Themba CLC**, regarding your child's participation at **Themba CLC**. Throughout this Agreement and attachments, the terms "you" and "parent" refer to the parents or legal guardians of the child enrolled at the Center, and the terms "Center" and "we" refer to **Themba CLC** and its staff members. The term "school day" means a day when the Center is open and operating.

By executing this Agreement, You _____, agree to enroll
(parents or guardians)
your child, _____ at **THEMBA CLC**, and **THEMBA CLC** agrees to accept your
(name of child)
child's enrollment, under the terms and conditions as stated below:

1. Program and Hours of Care.

Beginning on _____, 20____, the Center will provide care for your child at **THEMBA CLC** in
the _____, classroom with the following schedule:

_____ Full-time: Weekdays from _____ a.m. until _____ p.m.

_____ Part-time: Circled days: Mon. Tues. Wed. Thurs. Fri. From _____ a.m. until _____ p.m.

2. Payment (If Enrolled in the Before and After Care Program).

a. Registration Fee. A non-refundable Registration Fee of _____ for a single child and _____ for family is due and payable on the date your child's Enrollment Application is returned. Payment of this fee will place your child on the waiting list if no space is available at the time you apply. Registration is renewed annually by June 1 for September enrollment.

b. Enrollment Deposit. Upon executing this Agreement, you have paid an Enrollment Deposit of \$_____. This Enrollment Deposit will serve as security for the performance of your obligations under this Agreement, including non-payment of tuition, late fees, damage, or other charges. If you terminate this Agreement with at least one month's written notice, your Enrollment Deposit may be credited to your last month's tuition. Themba only credits the last month's tuition. Credits are not transferrable to any other accounts. If you do not give at least one month's written notice of termination of enrollment, or if you fail to begin enrollment within 30-days of agreed upon time, this Enrollment Deposit will be forfeited in full.

c. Tuition. Tuition for your child will be \$_____ per _____. **Weekly tuition is due each Monday before noon. Monthly tuition is due on the first school day of each month. Part-time tuition is due the first day of your child's enrollment schedule (Monday-Wednesday-Friday or Tuesday-Thursday). Weekly tuition is late and is subject to a late fee of \$10.00 per day on Monday at noon. Monthly tuition is late on the second school day of the month at noon and is subject to a late fee of \$10.00 per day until paid.**

d. Coupon Credit. You will receive a credit of \$_____ per _____ for a coupon or special enrollment rate until _____ (date). Prior to that date, your tuition will be \$_____ per _____. After that date, your tuition will be as stated above. Coupon credit will only be allowed if all tuition payments are made on time.

3. Method of Payment.

All tuition payments are made through our automated payment processing, **Tuition Express (See forms Attached)**. Your payment processing may be setup through credit card or bank draft. No other payment methods are accepted. If any automated payment is returned unpaid, you will owe a service fee of \$35.00 in addition to other amounts due.

4. Late Fees, Suspension, and Termination for Late Payment.

A late fee of **\$10.00 per school day** will be charged everyday by noon if your week's tuition is not paid by the due date as required in the enrollment agreement. The due date for tuition is **Friday**. Your grace period is **Monday by noon**. If the Center has not received your tuition by the due date for your weekly tuition (or by the fifth calendar day of the month for monthly tuition), the Center may refuse to admit your child to the Center until you pay the amount due. The Center also reserves the right to terminate your child's enrollment for non-payment. You hereby agree that, if **Themba CLC**, has to take collection action to collect unpaid fees, you will be responsible for all accrued late charges until the date collected, and for reasonable collection costs, including attorney's fees. _____ initial

5. Late Pick-Up Penalties.

If your child is picked up after the scheduled closing time of 6:30pm for B&A and 3pm for Pre-K, you will owe a late fee of \$15.00 for up to the first 5 minutes and \$1.00 for each additional minute. These late pick-up penalties must be paid immediately to the staff attending to your child. If your child is picked up more than thirty (30) minutes late two (2) or more times in any thirty (30)-day period, the Center may terminate your child's enrollment. _____ initial

6. Damage to Center Property.

You hereby agree that you will be responsible for any damage to Center property or equipment caused by you or your child, normal wear and tear excepted, including repairs made necessary by your actions or your child's actions.

7. Changes in Tuition.

You understand that tuition rates are subject to change, and you agree that you will pay the new rate after the Center gives you at least thirty (30) days notice of such change.

Parent's Signatures _____

8. Absences.

You are responsible for paying full tuition for your child until you terminate the enrollment, even if your child is absent due to illness, vacation, or other causes. You agree to notify the Center in writing at least one month in advance if your child will not attend due to vacation or other plans. _____ initial

9. Readmission After Illness.

State licensing regulations require that, if your child has been ill, he or she may not be readmitted to the Center until he or she is free of symptoms for 24 hours without any medications. You hereby agree to abide by this requirement and agree that the decision of the Center Director shall govern such a readmission. _____ initial

10. Holidays and Other Closings.

The Center will be closed on the following holidays: New Year's Day, Martin Luther King, Jr.'s Birthday, Columbus Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, and the day after, Christmas Day and the day after. If any holiday falls on a Saturday or Sunday, **Themba** may be closed on the following Monday. **Themba** is also closed 2-3 days per year for staff participation. Tuition is due in full for these days. _____ initial

** Themba is not a religious school, therefore Themba doesn't single out any one religious holiday to celebrate in our classrooms in order to show respect for other religious holidays that may be celebrated by our families. _____ initial

11. Inclement/Emergency Closings

Sometimes Themba must close because of emergencies or inclement weather. When you are not sure about the closing of the center, please call the office by 5:30am or check our website, www.thembacdc.com for updates. Themba will also send out an alert by email and or text. Tuition fees are still due during emergency and/or inclement weather closings. Refunds or credits will not be given.

12. Suspension.

In the judgment of the Center Director, or designate, if the child's behavior threatens the physical or mental health of other children or of the staff of the Center, the Center Director or designate will call the parent(s) or guardian(s) to remove the child for the rest of the day. **THEMBA** requires that the child be picked-up within the hour of being notified. Parent or guardian continues to be responsible for daily tuition for that day.

13. Withdrawal by Parent.

You must give the Center Director at least one month's notice in writing if you wish to withdraw your child from the Center. If you give such notice and if an enrollment deposit was received during enrollment, you may use your such Deposit as a credit against your last month's tuition. If you do not give such notice, and a deposit was not received at enrollment, you will still be responsible for your entire last 30-days tuition.. If you do not give such notice, your entire Enrollment Deposit and any prepaid tuition will be forfeited. _____ initial

14. Termination by Center.

a. Immediate. The Center may terminate your child's enrollment in the Center, effective immediately, if any of the following conditions arise:

(1) In the judgment of the Center Director, the child's behavior or the parent's behavior in the Center threatens the physical or mental health of other children or of the staff of the Center;

(2) **Tuition is not paid on or before the fifth calendar day of the month if tuition is paid monthly, or by Wednesday at noon if tuition is paid weekly;**

(3) The child is routinely picked up later than the Center closing time or more than thirty (30) minutes late two (2) or more times in a one month period.

(4) The child is ill when brought to the Center more than three (3) times within any thirty (30)-day period, or the parent fails to pick up a sick child within one hour after being notified of the sickness more than two (2) times during any six (6) month period.

If enrollment is terminated because of any of the above conditions, the Enrollment Deposit will not be refunded, and may not be used as a credit against unpaid tuition, and any prepaid tuition will be forfeited. _____initial

b. Two Weeks' Notice. The Center may terminate your child's enrollment upon two (2) weeks' notice to you if any of the following conditions arise:

(1) Any of the conditions listed in (a) above has occurred, and the Center has not exercised its right to terminate enrollment immediately;

(2) In the judgment of the Center Director, the Center's program does not meet the developmental or special needs of your child;

(3) You fail to provide necessary items, such as cot sheets, diapers, lunches, etc., as described in the Parent Handbook;

(4) You fail to abide by the terms of this Agreement. _____ initial

If your enrollment is terminated under this section (b) for reasons other than non-payment of tuition, you will be allowed to use your Enrollment Deposit as a credit toward your tuition. If your enrollment is terminated for non-payment of tuition, your entire Enrollment Deposit and any prepaid tuition will be forfeited.

15. NEW POLICIES!!!

No Cell Phone Zone For All!!

Themba is a no cell phone zone! Parents please refrain from using your cell phone at Themba during pick up and drop off. Teachers have very limited times to communicate with you, so please be available to chat with them at these times. Please do not see cell phones on field trips when you are responsible for supervising other peoples children. _____ initial

NO Hair Beads

NO Hair Beads Policy- Due to the number of beads that are found on the floor and in children's mouths and even noses, we have been forced to implement a NO HAIR BEADS policy for the daycare center. Please do not put beads in your child's hair. If they come to school with beads in their hair we will remove them. They pose a serious danger to all children in the center. _____ initial
(Before/After Care Students are Exempt from this policy)

Safety

For Safety reasons, please do not hold the front door open for anyone. Every parent must use their code to enter the building. If the person doesn't have a code, please allow them to ring the door bell and show ID. _____ initial

Parking

Please do not park in the fire lane or in the circle. All cars must be parked in a parking space. _____ initial

16. Field Trip Participation.

You acknowledge and agree that the Center's regular program includes field trips and other off-premises activities that involve transporting the children on public transportation, in chartered vehicles, or in vehicles that are driven by **THEMBA CLC** staff and parent volunteers. You will be asked to sign a separate Field Trip Permission Form for each excursion. **You acknowledge and agree that no alternate care may be available at the Center in case you do not wish your child to attend such field trip or field trips, and that no tuition refund will be given in such case.**

Each parent **must** participate in and attend one field trip per year with their child(ren). _____

If the Center Director or Senior Staff determines that the child needs individual attention, the parent(s) may be requested to attend the field trip with the child, or the child may not be allowed to participate. No alternate care will be provided in this case.

17. Publicity and Outside Consultants.

Do you grant permission for your child to be photographed or captured via digital imagery, video taped, for publicity or news purposes or interviewed by outside consultants for Print, Web and Social Media marketing and educational purposes? _____ YES
_____ NO

18. Liability Release.

THEMBA CLC maintains an insurance policy to cover its liability for injuries, losses, and damage that may occur to your child, your child's property, or your property caused by fire, theft, storm, or other causes. Acting on behalf of yourself and your child, you hereby waive and agree to release any claims that you, your child, or your child's heirs and successors may have against **THEMBA CLC**, or any successor corporation, or against any officer, shareholder, employee, or agent of **THEMBA CLC**, or any successor corporation, for any and all injuries, losses, and damage to your child, your child's personal property, and your personal property to the extent that those injuries, losses, and damage are not covered by the insurance policy maintained by **THEMBA CLC**, or any successor corporation, or to the extent that the monetary amount of such injuries, losses, or damage exceed any amount payable under such insurance policies. You agree to be responsible for and hold harmless **THEMBA CLC**, any successor corporation, and any of the officers, shareholders, or directors of **THEMBA CLC**, or any successor corporation from and against any and all claims, suits, judgments, or costs that may be brought against **THEMBA CLC**, any successor corporation, its officers, employees, shareholders, or agents of **THEMBA CLC**, for the actual or alleged acts or omissions of you or your child(ren).

19. Certification That All Information Is Correct.

The following attachments form a part of this Enrollment Agreement. You hereby certify that you have accurately completed all the forms listed below, and that you have read and agree to abide by all provisions of the Parent Handbook. You agree to notify **Themba** if there is any change in the information you have supplied on the forms listed below:

- a. Deposit Acknowledgment/Receipt (If applicable)
- b. Developmental History Form
- c. Pick-Up Release Form
- d. Custody Information Form (if applicable)
- e. Emergency Information Cards (2)
- f. Authorization to Treat a Minor Form (notarized)
- g. Child Health Inventory and Immunization Record.
- h. Receipt of Parent Manual

20. Severability/Unenforced Terms Not Waived.

If any term of this Agreement is declared invalid or unenforceable, it will be severed and all other terms will remain effective, and they will be construed as though the invalid or unenforceable term did not exist. If **Themba CLC**, elects not to require that you comply with any term of this Agreement, **Themba CLC**, will not be deemed to have waived its right to demand compliance with said term at a later time.

AGREED TO

Parent's or Guardian's Signature _____ Date _____

Parent's or Guardian's Signature _____ Date _____

Center Director's\Assistant Director's Signature Date

EMERGENCY FORM

Check the meal(s) that your child receives: BF __ AM __ LUN __ PM __ SUP __

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. 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:		

Dad's Email _____ Mom's Email _____

Name of Person Authorized to Pick Up Child (*daily*) _____Address _____
Last First Relationship to Child
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 FirstAddress _____
Street/Apt.# City State Zip Code2. Name _____ Telephone (H) _____ (W) _____
Last FirstAddress _____
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 childcare 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



Automated Payment processing Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR **BANK ACCOUNT** ELECTRONIC FUNDS TRANSFER

I (we) hereby authorize Themba Creative Learning Center to initiate debit entries to my (our) Checking or Savings once per ____ Week or ____ Month (check one option) in the amount of \$_____ against the account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____		Phone # _____	
Address _____		City _____	State _____ Zip _____
Bank or Credit Union Name _____			
Bank or Credit Union Address _____		City _____	State _____ Zip _____
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Routing Transit Number (see sample below) _____		Account Number (see sample below) _____	
Signature _____		Date _____	

For Official Use Only...

Date Received _____

Employee Signature _____

John Sample Mary Sample 123 Nice Street Anytown, USA		BANK OF THE WEST 555-555-5555		00226
Pay to the order of: _____		Attach Voided Check Here \$ _____		
_____		Deposit slips not accepted _____ Dollars		
123456789	1800338	0226		
Routing Number	Account Number	Check Number		

A service of



procure
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Automated Payment processing Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

AUTHORIZATION FOR **CREDIT CARD**

I (we) hereby authorize Themba Creative Learning Center to initiate recurring credit card charges once per ____Week or ____Month (check one option) in the amount of \$_____to the below referenced credit card account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Please contact Center Representative for a list of Credit Cards Accepted as Payment.

Cardholder Name

Phone #

Cardholder Address

City

State

Zip

Credit Card Number

Expiration Date

Signature

Today's Date

For Official Use Only...

Date Received

Employee Signature

A service of



- - - - - < Cut Here > - - - - -

FULL Credit Card Number

Expiration Date

Security Code (3 digits)

For Security, please...

☐ return this Section of the Authorization Form.

☐ Shred this Section of the Authorization Form.

Today's Date



**Late Fee Pick-Up Policy Change
Effective April 26th 2014**

Dear Parents:

Due to the large number of children remaining at Themba after closing, the following policy is effective within 30 days.

Themba Creative Learning Center closes at 6:30pm. It is suggested that children be picked up by 6:25pm. Children not picked up by 6:30pm will be brought into the front office to wait for their parents and the late pick-up fee will begin to be assessed.

Your child anticipates your arrival and becomes worried and anxious if his/her classmates have all been picked-up while his/her parents have yet to appear. Additionally, our staff puts in an entire full day at Themba; and understandably, they are ready to return to their families, and carry out their personal plans for the evening. It is unreasonable to impose such inconvenience upon them.

Out of respect to our staff and their time, please make arrangements to pick-up your child before the close of business. Be advised that if you arrive after 6:30pm, you will be presented with a late fee form, assessed for the total amount of time for your late arrival. **With no exception, LATE FEES ARE PAYABLE AT PICK-UP.**

Late fees are payable in cash, personal checks, or credit cards (with the appropriate processing fee). You will be asked to sign a late fee Pick-up Form at your arrival.

Late Fee Per Child: \$15.00 for up to the first 5 minutes
\$1.00 for each additional minute

Fees are payable directly to the office staff.

If a family has an emergency near the end of the day, such as a car breaking down an illness, or traffic jams, parents must first inform the Center, and then make alternate plans for pick-up. The late fee will be imposed even under emergency conditions.

After six incidents of late pick-ups, your child will not be able to attend the Center for the next day; additionally, your late pick-up record will be reviewed in consideration for future enrollment with THEMBA.

Refusal to pay assessed late fees or confrontational behavior towards our staff concerning the late fee assessments is strictly prohibited and will jeopardize your child's enrollment at THEMBA.



6715 Cipriano Road, Lanham- Maryland 20706 *301-552-5437 * 301-552-7565 fax *www.thembaclc.com

RE: Healthy & Nutritious Meals/Snack Policy Since 2008

Themba Creative Learning Center provides nutritious breakfast/snacks and milk as part of your child's program. In addition, parents may decide to participate in a hot lunch program provided by Good Foods Catering Company, or bring a healthy lunch from home.

Themba CLC, promotes healthy eating habits and a positive attitude about food. Serving healthy food at preschool sets a great example for children and can be simple to prepare. Try to include at least 2 food groups for variety and balanced nutrition. Snacks/ Meals should be low in fat and sugar. Drinks may include milk, water, or 100% fruit juice.

Themba CLC is a nut free school, please check labels accordingly and DO NOT bring any snacks/meals containing any nut products.

Prohibited Foods

The following potential hazards may not be included in children's lunches sent from home: hotdogs (neither whole nor pieces), nuts, popcorn, raisins, raw peas, corn, raw carrots, hard pretzels of any size, or whole grapes. Meat must be cut in a portion that can be safely swallowed whole. ** Please see birthday celebration Guidelines about prohibited foods**

Also, in order to prevent injuries from breaking glass, please do not send drinks in glass bottles. Juice boxes are easy for the children to handle; "Capri Sun" foil containers are not.

Suggested food items are: fruits & vegetables with low fat dips, 100% juice, tortilla chips and salsa, yogurt, fruit muffins, animal crackers, mozzarella sting cheese, multi-grain chips, pretzels, pita bread chips, rice cakes, granola bars/no nuts, bagels, cereal bars, oatmeal meat, dry beans..

Themba will not allow any junk food including birthday cake or fast food to be consumed in the facility. Please serve your child before entering into the center any fast food/junk food products. Soda's are not allowed in the center.

Please do not send candy. A child with candy in her lunch will be asked to place it back in her cubby/lunchbox until pick up time. Teachers ask that on the rare occasion when you bring in food from a fast food establishment, you take the toy and food out of the bag, and present the food separately on a plate. The bag and the toy can be kept in your care until you pick up your child at the end of the day.

References: USDA Child and Adult Care Food Program/NAC Accreditation



6715 Cipriano Road, Lanham- Maryland 20706 *301-552-5437 * 301-552-7565 fax *www.thembacdc.com

Healthy Foods For Celebrations Policy revised 8/19/13

Please help us encourage lifelong healthy habits among our children. We encourage parents to join us for their child's birthday or other special occasions.

Typically, foods for celebration includes cupcakes, candy, cookies and other "treats" that have a large amount of sugar, calories and fat. There is nothing wrong with an occasional treat, but unhealthy choices have become the norm rather than the exception.

Please submit this form to the classroom teacher one week before your child's birthday party. All parties must start by 3:30pm and end by 4:30pm. Themba does not allow balloons since they are a major cause for choking in young children, **home cooked food, cakes/cupcakes or unhealthy snacks are also prohibited.**

The following is a list of alternatives our facility will allow for celebrations/special occasions that promote and reinforce good nutrition.

Please check all items you may bring to the party.

100% Juice boxes_____	Yogurt _____	Fruit Smoothies_____	
Tortilla chips and salsa_____	Fruit Muffins_____	Dried Fruit_____	
Favors_____	Pretzels_____	Fresh Fruit/Vegetable_____	Animal
Crackers_____	Crackers with cheese_____		
Flavored Milk_____	Mozzarella string cheese pack_____		
Cheese Pizza Only_____	Decorations/paper products_____		
Other_____	Goodie Bags/No Candy_____		
	Entertainment Name_____		

** If you would like something other than the items listed above please speak with the director for approval.

Child's Name _____ Date of Party _____

Parent's Signature _____ Limit two outside guest _____

Teacher's Signature _____ Director's Signature _____



6715 Cipriano Road, Lanham- Maryland 20706 *301-552-5437 * 301-552-7565 fax *www.thembaclc.com

Guidelines for Healthy Celebrations

Please help us encourage lifelong healthy habits among our children. We encourage parents to join us for their child's birthday or other special occasions.

Our facility will only allow healthy foods for celebrations. If you feel that you want to provide "treats" for a special celebration here is a list of non-food suggestions:

Stickers	Decorative pencils
Little toys	Party hats/Favors
Erasers	Bubbles
Finger/hand puppets	Whistles
Glow in the dark items	Rubber stamps
Party Favors	Fake Tattoos
Fake teeth	Toothbrushes

Before bringing items to the facility, make sure the items you wish to bring are approved and age appropriate for the celebrating group.

Depending on the size and the number of children in your child's class, providing treats or gifts to all the children could become costly. Here are a couple of low-cost, easy ideas that will give your child a memorable experience on their special day:

- Decorate your child's classroom. Example: A banner with the child's name and "Happy Birthday." This will make your child feel special during the celebration/special occasion without adding unneeded fat and sugar in the diet.
- Take time to have a meal with your child at the center. This gives your child personal attention.
- Buy or supply a special book to be read during the day. Make it even more special by coming to your child's class to read the story.
- Plan and provide a special craft project for your child's class.

2015-2016 Meal Benefit Application for Themba Creative Learning Center, LLC

For more information, read **Instructions for Applying** or call: _____

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 (✓) if foster child, homeless, migrant, runaway, in Head Start, Early Start or Even Start

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)

All Household Members (including yourself) – List all Household Members (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income and how often for each source in **whole dollars only**. If they do not receive income from any source, write '0'. **If you enter '0' or leave any fields blank you are certifying (promising) that there is not 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 the center will receive Federal funds based on the information I give. I understand that center officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted. 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. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

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. FOR 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): \$ _____

Eligibility: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature and Date Determined: _____

Date Withdrawn: _____



SHELTER –IN PLACE PROCEDURES

Dear Parents,

Due to the challenging times we are living in, we have added a new procedure to our school safety and security plan. This plan was designed with the help of MEMA (Maryland Emergency Management Agency), law-enforcement and public health officials.

Public health officials advise us that a shelter-in-place will help protect children from exposure to dangerous chemicals in the event of a biological attack, and the air became unsafe to breathe.

If dangerous chemicals are released in the community and posed a threat to children during the day, we would be directed, by public health or safety officials to bring all children and staff indoors and to close and secure all doors and windows.

Public safety officials have informed us that the neutral atmosphere pressure created by these actions would create a barrier and help keep chemical agents from leaking into the building. This approach is proven to be safe, much safer than evacuating into contaminated outdoor environments.

During a shelter-in-place incident, our building would be secured and no people will be allowed in or out of the building until an all-clear signal is given from health officials. To ensure that we can adequately provide for all students in the event of an emergency, all parents must prepare an individual emergency kit for their child and send it in ASAP. All items must be placed in a 2 gallon zip-lock bag.

EMERGENCY PREPAREDNESS ITEMS

(Place all items in a 2 gallon zip-lock bag)

PLEASE PUT YOUR CHILD’S NAME ON ALL ITEMS

Two,Three & Four Year Old	Infants/Toddlers Only
2-16oz bottles of water	Pack of diapers or pull-ups
1-Emergency Blanket Myler	2-Complete changes of clothes
1-Large Pack of Wet Ones	2-Bottles of juice
2-Cans of tuna fish with flip top, or similar item with a flip top that you know your child would eat straight from the can.	4-Cans of baby food
2-Packs of Crackers	4-Individual serving cans of baby formula(if your child is still using formula)
2-Cups of applesauce	1-Small comfy toy
2-changes of clothes and pull-ups	1-Pack of wet ones
2-Day supply of any medicine your child may be taking	

Before and After School Parents: please pack 2bottles of water, crackers, non perishable can foods with a flip top, a blanket, and a(2) day supply of medicine that your child may be taking.

Headlines From Home

Child's Name _____ Child's Current Age _____ Date _____

Your Name _____ Your Relationship to the Child _____

1. What are your child's favorite activities at home?

2. What are some of your child's strengths?

3. Do you feel that the developmental needs of your child are being met?

4. Do you presently have any concerns about your child that you would like to discuss?

5. Is there anything away from our setting that may be affecting your child's behavior?

6. What learning and growth goals do you have for your child (short-term and/or long-term)?

7. Please list other topics or questions you would like to talk about.

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://ideha.dhmf.maryland.gov/IMMUN/pdf/896_form.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://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/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

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

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

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>
Last First Middle			Mo / Day / Yr		
Address: _____					
Number Street		Apt#	City	State	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W: _____	C: _____	H: _____	
		W: _____	C: _____	H: _____	
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 _____

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: _____ <div style="text-align: center; font-size: small;">Last First Middle</div>			Birth Date: _____ <div style="text-align: center; font-size: small;">Month / Day / Year</div>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
1. Does the child named above have a diagnosed medical condition? <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____								
3. PE Findings								
Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated	
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
REMARKS: (Please explain any abnormal findings.) 								
4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmmh.maryland.gov/IMMUN/pdf/896_form.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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction: _____								
7. Test/Measurement	Results			Date Taken				
Tuberculin Test								
Blood Pressure								
Height								
Weight								
BMI %tile								
Lead Test Indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No								

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

Additional Comments:

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

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

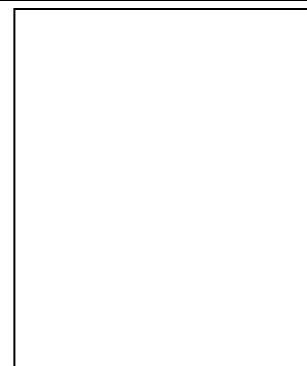
Allegany ALL	Baltimore (cont) 21220 21221	Cecil 21913	Garrett ALL	Montgomery 20783 20787	Prince George's (cont) 20782 20783	St. Mary's 20606 20626
Anne Arundel 20711 20714 20764 20779 21060 21061 21225 21226 21402	21222 21224 21227 21228 21229 21234 21236 21237 21239 21244 21250 21251 21282 21286	Charles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

**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.
- An adult must bring the medication to the facility.



Child's Picture

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 - Specify: _____

Medication shall be administered from: _____ to _____
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/We certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

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

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

[illegible]

THEMBA CREATIVE

Early Learning Centers

Medical Authorization to Treat a Minor

Authorization is given to any one of the following:

THEMBA CREATIVE Early Learning Centers and staff members acting as agents of THEMBA CREATIVE Early Learning Centers

From:

Full name of parent(s) or guardian of child

Address and phone number

to consent to unexpected or emergency medical and dental treatment and surgical care for my/our child/children on my/our behalf, and to consent to hospitalization if, at time of injury or illness, it is recommended by a private physician or consulting physician.

Name(s) of Minors	Birthdates	Allergies & Special Conditions
-------------------	------------	--------------------------------

1		
2		
3		
4		

I/We will be responsible for charges incurred for any emergency service, including; ambulance, medical, dental or surgical treatment and/or hospitalization rendered by reason of this authorization.

For further emergency Contact please provide Child's mother and father employer information:

Mother Employer _____

Address _____ City _____ State _____

Phone _____

Father Employer _____

Address _____ City _____ State _____

Phone _____

Signature of Parent

Date

Signature of Parent

Date

FAMILY INFORMATION

1

Name of child _____ DOB _____

Known allergies _____

Medications child is taking _____

Pediatrician _____ Phone _____

Dentist _____ Phone _____

Insurance Company _____ Phone _____

Member's name _____

Identification Number _____

2

Name of child _____ DOB _____

Known allergies _____

Medications child is taking _____

Pediatrician _____ Phone _____

Dentist _____ Phone _____

Insurance Company _____ Phone _____

Member's name _____

Identification Number _____

3

Name of child _____ DOB _____

Known allergies _____

Medications child is taking _____

Pediatrician _____ Phone _____

Dentist _____ Phone _____

Insurance Company _____ Phone _____

Member's name _____

Identification Number _____

4

Name of child _____ DOB _____

Known allergies _____

Medications child is taking _____

Pediatrician _____ Phone _____

Dentist _____ Phone _____

Insurance Company _____ Phone _____

Member's name _____

Identification Number _____

ADDITIONAL INFORMATION

The Maryland Child Care Credential

Maryland has a voluntary child care credentialing program that recognizes child care providers' education, experience and professional activities at six levels.

Credentialed providers are authorized and encouraged to display the seal issued by the MSDE Office of Child Care.



Program Accreditation

Child care programs have the option of becoming state or nationally accredited. Accreditation means that the facility and staff have met program standards of quality.

Child Care and the Americans with Disabilities Act

The federal Americans with Disabilities Act (ADA) requires all child care programs to make reasonable efforts to accommodate children with disabilities. For more information about the ADA, please contact the OCC Regional Office in your area or one of the following organizations:

LOCATE: Child Care

Maryland Committee for Children, Inc.
608 Water Street
Baltimore, MD 21202
Phone: (410) 752-7588
www.mdchildcare.org

Maryland Developmental Disabilities Council

217 East Redwood Street, Suite 1300
Baltimore, MD 21202
Phone: (410) 767-3670
(800) 305-6441 (within Maryland)
www.md-council.org



State of Maryland

Martin O'Malley, Governor

Maryland State Department of Education

Nancy S. Grasmick
State Superintendent of Schools

OCC 1524 (rev. 12/2007)

A PARENT'S GUIDE

TO



REGULATED

CHILD CARE

* * *

*Important Information for
Parents of Children in
Child Care Facilities*

A publication of the
Maryland State Department of Education
Division of Early Childhood Development
Office of Child Care

www.marylandpublicschools.org/MSDE/divisions/child_care/child_care.htm

This Brochure Provides Information About:

- The requirements that State-regulated family child care homes and child care centers must meet,
- Your rights and responsibilities as the parent of a child in regulated care, and
- How and where to file a complaint if you believe your child care provider has violated State child care licensing regulations.

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education (MSDE), Division of Early Childhood Development. Within the Division, child care licensing is the specific responsibility of the Office of Child Care (OCC), Licensing Branch.

All child care facilities must meet minimum health, safety, and program standards set by Maryland law. To remain licensed, facilities must maintain compliance with those standards. Every licensed facility is inspected by OCC at least once each year to evaluate the facility's compliance with child care regulations.

OCC's thirteen Regional Offices are responsible for licensing activities, including:

- Issuing child care licenses;
- Inspecting child care facilities;
- Investigating complaints against licensed child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary to achieve compliance with regulations.

There are two types of regulated child care facilities: *family child care homes* and *child care centers*.

Family Child Care Homes and Child Care Centers Must Meet the Following Requirements:

- Have the approval of OCC, the fire department and other local agencies, as required (i.e., zoning, health, and environment).
- Provide care only in the areas of the facility that have been approved for use.
- Have the license issued by OCC posted where it is easily and clearly visible to parents. The license shows:
 - the maximum number of children who may be present at the same time;
 - the age groups which may be served; and
 - the facility's approved hours of operation.
- At all times, each child must be supervised in a manner appropriate to the child's age, activities, and individual needs.
- All areas of the facility used for child care must be clean, well lit, and properly ventilated. Room temperatures should be comfortable.
- If food service is provided, food must be stored, prepared, and served in a safe, sanitary and healthful manner.
- The facility must offer a daily program of indoor and outdoor activities that are appropriate to the age, needs and capabilities of each child.
- An up-to-date emergency information card must be on file and maintained for each child.
- The facility must post an approved emergency evacuation plan and conduct evacuation drills at least monthly.
- Child discipline procedures must be appropriate to a child's age and maturity level and may not include the deliberate infliction of physical or emotional pain. ***Corporal punishment of any kind is strictly prohibited.***

There are certain requirements that apply only to homes or centers.

Family Child Care Homes

- Up to 8 children may be in care at the same time if the home meets certain physical requirements. No more than 2 children under the age of two, including the caregiver's own, may be in care at the same time unless the home has been approved to serve additional children in this age group and an additional adult is present. Under no circumstance may care be provided at the same time to more than 4 children under the age of two.
- Each applicant for a family child care license must:
 - Have a criminal background check and child abuse/neglect clearance;
 - Submit a recent medical evaluation; and
 - Complete pre-service training requirements, including certification in first aid and CPR.
- Each adult resident of the home must also have a criminal background check and child abuse/neglect clearance.
- After becoming licensed, the caregiver must periodically complete additional training. Also, current certification in first aid and CPR must be maintained at all times.
- Each caregiver must have at least one substitute who is available to care for the children in the event of the caregiver's temporary absence from the home. Each substitute is subject to approval by OCC and must have a child abuse/neglect clearance. If paid by the caregiver, a substitute must also have a criminal background check. Before allowing a substitute to provide care, the caregiver must tell the substitute how to reach parents in the event of an emergency and familiarize the substitute with the home's child health and safety procedures.

Child Care Centers

The center director and staff members who have group supervision responsibilities must meet minimum education, experience, and training qualifications. They must also meet continued training requirements each year.

The director and all paid center employees must complete a criminal background check and a child abuse/neglect clearance, and submit a medical evaluation.

- In each classroom, staff/child ratios and maximum group size requirements must be maintained at all times. The following table shows some basic age groupings and the applicable requirements:

<u>Age Group</u>	<u>Ratio</u>	<u>Maximum Size</u>
0 –18 months	1:3	6
18 – 24 months	1:3	9
2 years	1:6	12
3 –4 years	1:10	20
5 years or older	1:15	30

- For every 20 children present, there must be at least one staff member who is currently certified in first aid and CPR.

Your Rights and Responsibilities as a Child Care Consumer

You have the right to:

- Expect that your child's care meets the standards set by Maryland's child care licensing regulations (NOTE: the regulations are available online at: www.marylandpublicschools.org/MSDE/divisions/child_care/regulat);
- Visit the facility without prior notification any time your child is there;
- See the rooms and outside play area where care is provided during program hours;
- Be notified if someone in the family child care home smokes. In child care centers, smoking is prohibited;
- Receive advance notice when a substitute will be caring for your child in a family child care home for more than two hours at a time;
- Give written permission before a caregiver may take your child swimming, wading, or on field trips;
- Give written authorization before any medication may be administered to your child;
- Be notified immediately of any serious injury or accident. If your child has a non-serious injury or accident, you must be notified on the same day;
- File a complaint with OCC if you believe that the caregiver has violated child care regulations.

Any complaint you make to OCC about the care your child is receiving will be promptly investigated by OCC;

- Review the public portion of the licensing file for the facility where your child is or has been enrolled, or where you are considering enrolling your child.

How Do I File a Complaint?

If you wish to file a complaint, contact the OCC Regional Office in the area where the child care facility is located. Complaints may be filed anonymously. Listed below are Regional Offices and their main telephone numbers:

Region

1 – Anne Arundel County	410-514-7850
2 – Baltimore City	410-554-8300
3 – Baltimore County	410-583-6200
4 – Prince George's County	301-333-6940
5 – Montgomery County	240-314-1400
6 – Howard County	410-750-8770
7 – Western Maryland	
Hagerstown – Main Office	301-791-4585
Allegany Co. Field Office	301-777-2385
Garrett Co. Field Office	301-334-3426
8 – Upper Shore	410-819-5801
Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties	
9 – Lower Shore	410-713-3430
Somerset, Wicomico, and Worcester Counties	
10 – Southern Maryland	301-475-3770
Calvert, Charles and St. Mary's Counties	
11 – North Central	410-272-5358
Cecil and Harford Counties	
12 – Frederick County	301-696-9766
13 – Carroll County	410-751-5438

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated.

If you need additional help, you may contact the main office of the OCC Licensing Branch:

Program Manager, Licensing Branch
MSDE Office of Child Care
200 West Baltimore Street, 10th Floor
Baltimore, MD 21201
410-767-7805

Dear Parent/Guardian:

Maryland child care regulations require your child care provider to verify that you received a copy of "A Parent's Guide to Regulated Child Care." On the lines below, please write the name of each child you have placed in the care of this provider. **Complete and sign the statement at the bottom, tear off and give this portion of the brochure to the child care provider for retention in the facility's files.**

Child: _____

Child: _____

Child: _____

Child: _____

I, _____, have received
a copy of the consumer education brochure entitled
"Parent's Guide to Regulated Child Care."

Date

Signature of Parent/Guardian