



## CHECKLIST 2011-2012

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

- Health Inventory
- Emergency Form
- Student Data Sheet
- Parent's Guide to Regulated Child Care
- Medical Report for Child Care
- Release of Information
- Picture Release
- Handbook Acknowledgement (will receive at Orientation)
- Staff Orientation Check-off (will receive at Orientation)
- September & May Tuition; Check Number → \_\_\_\_\_

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____ Last First Middle	Birth Date _____
Name of Parent or Guardian _____	Relationship _____
Home Address _____	
City _____	State _____ Zip Code _____
Check Best Telephone Number to Reach You:	
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____ <input type="checkbox"/> Cell #: _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

**Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.**

**PLEASE RETURN THIS COMPLETED FORM TO:**

Name of Child Care Facility: \_\_\_\_\_

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

\_\_\_\_\_  
City/Town State Zip Code

**PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION**

To be completed by **PARENT/GUARDIAN**

**CHILD'S NAME:** \_\_\_\_\_

**IMPORTANT:** COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	<b>YES</b>	<b>NO</b>
1. Are you concerned about your child's general health ( <i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i> )?	_____	_____
2. Does your child have any eye problems ( <i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i> )? Date of last eye examination: ____/____/____      Doctor's Name: _____ Results: _____ Does your child wear glasses? _____ Contact lenses? _____	_____	_____
3. Does your child have any ear or hearing problems ( <i>frequent earaches, difficulty hearing, etc.</i> )? Date of last hearing evaluation ____/____/____      Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	_____	_____
4. Does your child have any speech problems ( <i>difficulty having speech understood, stammering, delayed speech development, etc.</i> )?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: (a) Does this condition require any special health care in the child care facility? _____ (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? _____ (c) Does your child require any special adaptations or adaptive equipment? _____	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

**REMARKS** (*Provide further explanation for all "YES" answers*): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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: MEDICAL INFORMATION**

To be completed by a **HEALTH PRACTITIONER**

**CHILD'S NAME:** \_\_\_\_\_

1. Date of this child's most recent tuberculin test: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_ Positive \_\_\_ Negative

**Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.**

2. Date of this child's lead screening: \_\_\_/\_\_\_/\_\_\_ Blood lead test dates: Test 1: \_\_\_/\_\_\_/\_\_\_ Test 2: \_\_\_/\_\_\_/\_\_\_

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS) \_\_\_\_\_
- a. Vision problem  YES  NO \_\_\_\_\_
  - b. Hearing problem  YES  NO \_\_\_\_\_
  - c. Speech or language problem  YES  NO \_\_\_\_\_
  - d. Other physical illness or impairment  YES  NO \_\_\_\_\_
  - e. Mental, emotional or behavior problems  YES  NO \_\_\_\_\_
  - f. Developmental delays  YES  NO \_\_\_\_\_
  - g. Allergies  YES  NO \_\_\_\_\_

Significant physical findings, comments and recommendations: \_\_\_\_\_

4. This child has a health condition which may require care or emergency action while at child care.  YES  NO  
 If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): \_\_\_\_\_

Recommendations: \_\_\_\_\_

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.  
 YES  NO If YES, please specify: \_\_\_\_\_

6. This child requires a modified diet and/or special feeding procedures.  YES  NO  
 If YES, please specify: \_\_\_\_\_

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?  
 \_\_\_\_\_

8. Does this child's physical activity need to be restricted?  YES  NO  
 If YES, please specify: \_\_\_\_\_

9. Does this child require any specialized treatment?  YES  NO  
 If YES, please specify: \_\_\_\_\_

10. Does this child require any adaptive equipment (braces, crutches, etc.)?  YES  NO  
 If YES, please specify type: \_\_\_\_\_  
 Special instructions for use: \_\_\_\_\_

**RECORD OF IMMUNIZATIONS**

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

**PART II: MEDICAL INFORMATION (CONTINUED)**

Child's Name \_\_\_\_\_

**MEDICAL CONTRAINDICATION:** The above child has a valid medical contraindication to being immunized at this time. This is a  permanent  temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_. Check appropriate box, indicate vaccine(s) and reasons: \_\_\_\_\_

**HEALTH PRACTITIONER'S STATEMENT:** To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care. (circle correct response)

\_\_\_\_\_  
Signature of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

**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 1<sup>st</sup> test was done prior to 24 months of age. **If a child is enrolled in child care during the period between the 1<sup>st</sup> and 2<sup>nd</sup> 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 1<sup>st</sup> 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	<u>Baltimore (cont)</u>	<u>Carroll</u>	<u>Frederick(cont)</u>	<u>Montgomery</u>	<u>Prince George's(cont)</u>	<u>St. Mary's</u>
<b>BY</b>	21210	21155	21783	20783	20783	20606
<b>ZIP CODE</b>	21212	21757	21787	20787	20782	20626
	21215	21776	21791	20812	20783	20628
<u>Allegany</u>	21219	21787	21798	20815	20784	20674
ALL	21220	21791		20816	20785	20687
	21221		<u>Garrett</u>	20818	20787	
<u>Anne Arundel</u>	21222	<u>Cecil</u>	ALL	20838	20788	<u>Talbot</u>
20711	21224	21913		20842	20790	21612
20714	21227		<u>Harford</u>	20868	20791	21654
20764	21228	<u>Charles</u>	21001	20877	20792	21657
20779	21229	20640	21010	20901	20799	21665
21060	21234	20658	21034	20910	20912	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237		21078	20913		21676
21226	21239	<u>Dorchester</u>	21082		<u>Queen Anne's</u>	
21402	21244	ALL	21085	<u>Prince George's</u>	21607	<u>Washington</u>
<u>Baltimore</u>	21250		21130	20703	21617	ALL
21027	21251	<u>Frederick</u>	21111	20710	21620	
21052	21282	20842	21160	20712	21623	<u>Wicomico</u>
21071	21286	21701	21161	20722	21628	ALL
21082		21703		20731	21640	
21085	<u>Baltimore City</u>	21704	<u>Howard</u>	20737	21644	<u>Worcester</u>
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	<u>Calvert</u>	21719	<u>Kent</u>	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204		21758	21645	20746		
21206	<u>Caroline</u>	21762	21650	20748	<u>Somerset</u>	
21207	ALL	21769	21651	20752	ALL	
21208		21776	21661	20770		
21209		21778	21667	20781		
		21780				

# 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.

When parents 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 \_\_\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Mother's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Mother's Employer/School \_\_\_\_\_  
Name Address

Mother's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Father's Employer/School \_\_\_\_\_  
Name Address

Father's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Name of Person Authorized to Pick Up Child (daily) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

**ANNUAL UPDATES** \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

**INSTRUCTIONS TO PARENT:**

- (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



**Student Data Sheet**  
(for teacher use only)

Child's Name: \_\_\_\_\_

Nick Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Interests & Motivators: \_\_\_\_\_

---

---

---

---

---

Fears: \_\_\_\_\_

Please list areas of learning that are important this year for your child: \_\_\_\_\_

---

---

---

---

Ethnic Holidays Celebrated: \_\_\_\_\_

Child Lives With: \_\_\_\_\_

Siblings' Names & Ages: \_\_\_\_\_

Health Problems/Allergies: \_\_\_\_\_

Please list all individuals who are authorized to pick up your child: \_\_\_\_\_

---

---

---

---

## 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.**

## 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](http://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](http://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](http://www.marylandpublicschools.org/MSDE/divisions/child_care/child_care.htm)



**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:

Age Group	Ratio	Maximum Size
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](http://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

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care  
**MEDICAL REPORT FOR CHILD CARE**

Name of Person being evaluated: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Child Care Applicant/Provider/Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Dear Health Practitioner:

The person to be evaluated either provides (or plans to provide) child care services or lives in a home where family child care is (or will be) given.

1) **RESTRICTED OR REQUIRE SPECIAL CONDITIONS** from contact with children in care due to having any of the following:

a) Communicable disease: \_\_\_\_\_

b) Chronic medical condition or physical impairment: \_\_\_\_\_

c) Vision/Hearing/Speech Disorder: \_\_\_\_\_

d) Nervous or Emotional Disorder: \_\_\_\_\_

e) Drug or Alcohol Abuse: \_\_\_\_\_

f) Immunization status: \_\_\_\_\_

2) Tuberculosis Screening: (if needed or required by the Local Health Officer.)

Type of test: \_\_\_\_\_ Results: \_\_\_\_\_ Date: \_\_\_\_\_

**Answer question 3 if the person being evaluated provides (or plans to provide) child care services:**

Persons who provide child care services must be able to participate fully in a program for active young children. This includes lifting infants and young children, getting up and down from the floor, lively outdoor activities, and moving furniture. It may also include transporting children in a motor vehicle.

3) Describe medical limitation(s) or medication(s) the person is taking, that may impair the person's ability to perform care-related activities, such as the ones noted above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician, CNP, RPA**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Phone Number**

**STAMP, PRINT, OR TYPE: Name and Address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.**





## Picture Release Form

---

Occasionally pictures from Mayo Nursery School appear in publications such as *The Capital*, our website ([www.MayoNurserySchool.com](http://www.MayoNurserySchool.com)), school-related publications, school projects, or bulletin boards. We want you to be aware that there is a possibility of a picture of you and/or child being published and/or used for school-related activities.

\_\_\_\_\_ YES, I give permission for Mayo Nursery School to use pictures of me and/or my child for school-related publications, projects, or marketing.

\_\_\_\_\_ NO, I do not give permission for Mayo Nursery School to use pictures of me and/or my child for school-related publications, projects, or marketing.

\_\_\_\_\_  
Child's Name – Please print

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date