Enrollment Packet

Last Updated: January 3, 2023

Welcome to the BabyFe Family! We are excited to join your family's village of caregivers. The following forms will help keep your little one safe and help us do our best to build on the quality of care you give in your home. We will keep the love (along with feeding and napping times) and add language enrichment and social engagement to your little one's daily routine. Please follow the directions below to begin this extraordinary journey!

Directions:

Step 1: Read the Parent's Handbook with your family

Step 2: Have a Physician fill out **Immunization, Health Inventory, Medication Administration Authorization Form** (If necessary), **and Emergency Form**

Step 3: Read and fill out all remaining documents in Enrollment Packet

Step 4: Verify in the Enrollment Checklist that you are not missing any documents.

Step 5: Scan and email all remaining documents, including a picture of your child for use in the classroom, to the Center Director at info@babyfe.com ***3 days before the first day of attendance***

Step 6: I will confirm receipt and give next steps for enrollment within 2 business days

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ______/______/______

COUNTY ______________________ SCHOOL ______________________ GRADE ______

PARENT OR GUARDIAN NAME ______________________ PHONE NO. ______________________

ADDRESS ______________________ CITY ______________________ ZIP ______

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr

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

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

2. ____
Signature Title Date

3. ____
Signature Title Date

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

Clinic / Office Name
Office Address/ Phone Number

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

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

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

Signed: ____ Date ______________
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: ____ Date: ______________

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered, or approved child care or nursery school:

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

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

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

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

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

Child's Name: ______________________________ (Last / First / Middle) **Birth date:** __________ (Mo / Day / Yr) **Sex** M☐ F☐

Address: ______________________________ (Number / Street / Apt# / City / State / Zip)

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Disorder	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

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

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

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

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

____
Printed Name and Signature of Parent/Guardian — Date

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

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

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

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

3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
☐ No ☐ Yes, describe:

4. Health Assessment Findings

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

REMARKS: (Please explain any abnormal findings.)

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

6. Is the child on medication?
☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

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

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

9. **RECORD OF IMMUNIZATIONS** – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

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

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

Additional Comments: ____________________

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME________________________/________________/________________
LAST FIRST MIDDLE

CHILD'S ADDRESS________________________/____________/____________/__________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE_____/_____/_____ PHONE________________

PARENT OR GUARDIAN________________________/________________/________________
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO

Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO

Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print):____________________**Signature**: ____________________ **Date**: __________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name:________________________ Signature:________________________

Date:________________________ Phone: ________________________

Office Address: ____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print):____________________Signature:____________________Date: __________

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name:________________________ Signature:________________________

Date:________________________ Phone: ________________________

Office Address: ____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711, 20714, 20764, 20779, 21060, 21061, 21225, 21226, 21402

Baltimore Co.
21027, 21052, 21071, 21082, 21085, 21093, 21111, 21133, 21155, 21161, 21204, 21206, 21207, 21208, 21209, 21210

Baltimore Co. (Continued)
21212, 21215, 21219, 21220, 21221, 21222, 21224, 21227, 21228, 21229, 21234, 21236, 21237, 21239, 21244, 21250, 21251, 21282, 21286

Baltimore City
ALL

Calvert
20615, 20714

Caroline
ALL

Carroll
21155, 21757, 21776, 21787, 21791

Cecil
21913

Charles
20640, 20658, 20662

Dorchester
ALL

Frederick
20842, 21701, 21703, 21704, 21716, 21718, 21719, 21727, 21757, 21758, 21762, 21769

Frederick (Continued)
21776, 21778, 21780, 21783, 21787, 21791, 21798

Garrett
ALL

Harford
21001, 21010, 21034, 21040, 21078, 21082, 21085, 21130, 21111, 21160, 21161

Howard
20763

Kent
21610, 21620, 21645, 21650, 21651, 21661, 21667

Montgomery
20783, 20787, 20812, 20815, 20816, 20818, 20838, 20842, 20868, 20877, 20901, 20910, 20912, 20913

Prince George's
20703, 20710, 20712, 20722, 20731

Prince George's (Continued)
20737, 20738, 20740, 20741, 20742, 20743, 20746, 20748, 20752, 20770, 20781, 20782, 20783, 20784, 20785, 20787, 20788, 20790, 20791, 20792, 20799, 20912, 20913

Queen Anne's
21607, 21617, 21620, 21623, 21628

Queen Anne's (Continued)
21640, 21644, 21649, 21651, 21657, 21668, 21670

Somerset
ALL

St. Mary's
20606, 20626, 20628, 20674, 20687

Talbot
21612, 21654, 21657, 21665, 21671, 21673, 21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

Maryland State Department of Education
Office of Child Care

Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.
Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's Picture Here (optional)

PRESCRIBER'S AUTHORIZATION

Child's Name:______________________________ Date of Birth: ___/_____/_____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from:___/___/_____ to ___/___/_____

If PRN, for what symptoms, how often and how long______________________________

Possible side effects and special instructions:______________________________

Known Food or Drug Allergies: ☐ Yes ☐No If yes, please explain:______________________________

For School Age children only: The child may self-carry this medication: ☐ Yes ☐No

The child may self-administer this medication: ☐ Yes ☐No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No**

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date __________ ☐ Yes ☐ No
2. Medication labeled as required by COMAR. ☐ Yes ☐ No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐ No ☐N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐ No ☐N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care
MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				**Date of Birth:**	
Medication Name:				**Dosage:**	
Route:				**Time to Administer:**	
DATE ADMINISTERED	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

CACFP Enrollment: Yes: ☐ No: ☐

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name ______________________________ Birth Date ______________
Last First

Enrollment Date ______________ Hours & Days of Expected Attendance ______________

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: ____________ W:	C:	H:
		Place of Employment: ____________ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* ______________________________
Last First Relationship to Child

Address ______________________________
Street/Apt. # City State Zip Code

Any Changes/Additional Information ______________________________

____

ANNUAL UPDATES ______________ ______________ ______________ ______________
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

2. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

3. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care ______________________________ Telephone ______________

Address ______________________________
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian ______________________________ Date ______________

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: ____

____

____

____

____

<u>Note to Health Practitioner:</u>

If you have reviewed the above information, please complete the following:

______________________________ ______________________________
Name of Health Practitioner Date

______________________________ (_____)_________________________
Signature of Health Practitioner Telephone Number

ENROLLMENT FORM

Enrollment Date___________________

BabyFe Bilingual Learning Center

Withdrawal Date___________

4861 Tesla Dr. Ste. A

Bowie, MD 20715

Child Information

Last Name:_________________________________

First Name:_________________________________

Nickname:_________________________________

Birthday:_________________________________

Gender:_________________________________

Group:

☐ Infant

☐ Cruisers

☐ Juniors

☐ PreK

Schedule:

M ☐ T ☐ W ☐ Th ☐ F ☐

Typical Hours: _______to_______

☐ Before care

☐ After care

Parent 1/Custodial/Guardian

Parent Information

Full Name:___________________________________

Date of Birth:________________________________

Social Security #:_____________________________

Drivers License #:____________________________

Address:_____________________________________

City:____

Zip code:____________________________________

Home Phone#:_________________________________

Employer/School

Work Phone #: _______________________________

Cell Phone #:_________________________________

Address:_____________________________________

Email address:________________________________

Parent 2/Custodial/Guardian

Parent Information

Full Name:___________________________________

Date of Birth:________________________________

Social Security #:_____________________________

Drivers License #:____________________________

Address:_____________________________________

City:____

Zip code:____________________________________

Home Phone#:_________________________________

Employer/School

Work Phone #: _______________________________

Cell Phone #:_________________________________

Address:_____________________________________

Email address:________________________________

Medical Information

Doctor:______________________________________

Location:____________________________________

Phone:______________________________________

Dentist:_____________________________________

Location:____________________________________

Phone:______________________________________

List allergies and intolerance to foods, medications or other substances____________________________

____

Action to be taken ____

____

If your child has allergies or is intolerant to any food please bring your MEDICATION ADMINISTRATION AUTHORIZATION FORM before bringing your child to BabyFe.

Authorization for Emergency Medical Care

(***Please Note***: *This authorization must be* ***NOTARIZED.***)

If I cannot be contacted in an emergency situation, I authorize the center's staff to obtain emergency medical treatment for my child.

Signature of Parent or Guardian____ Date _______________

Subscribed and Sworn to before me this ______________________ day of ___________________________

Notary Public: ____My Commission Expires: _____________

Child's Profile

Health

What communicable diseases has the child had?

☐ Meningitis	☐ Measles	☐ Mumps	☐ Polio
☐ Cringworm of Scalp	☐ Varicella	☐ Whooping Cough	☐ Rubella
☐ Salmonella typhi	☐ Streptococcal Infection	☐ Tuberculosis	☐ Scabies

Other____

Any chronic physical problem?____

Type of accommodations needed:____

Any developmental or learning need?____

** If special accommodations are needed, a current copy of the child's IEP or ISP is required.*

Medications

Are any medications given regularly? (*Please list medications and reasons*)

____

____

For any type of medication you must bring the medical prescription, the remedy in its original container and the *medication administration authorization form.*

Interests

Has he/she had experience playing with other children?

____

What are his/her favorite activities at home?

____

Does he/she like to: Be read to?___ Listen to music?___ Play outdoors?___Can he/she ride a tricycle?_____

Has he/she had experience with: Clay?___ Scissors?___ Painting?___ Blocks?___ Puzzles?___

In what particular ways can we help your child this year?

____

____

Describe your child briefly (personality, abilities, etc.)

____

____

____

Schooling

Please list any previous child care center enrollment:

Name of child care center

____

City/Town

____

State

____

Date

____

Name of child care center

____

City/Town

____

State

____

Date

____

Financial Agreement

I____*(please print full name),* the parent/guardian of ____ agree to pay my child's tuition no later than each Friday, I understand that if I do not pay on time I will automatically have a late fee of $ 25 that I have to pay. I also understand that if I do not pick my child up by the center's closing time I will incur a charge of $15.00 for any part of the first 30 minutes and $1.00 per minute after 30 minutes. If my child is enrolled in the before care and I do not pick my child up after 7p.m. I will incur a charge of $25.00 for any part of the first 30 minutes and $1.00 per minute after 30 minutes. I read and understood points number 6 and 15 in the handbook and I agree with all the charges mentioned. In the event that my child's tuition account becomes two weeks in arrears, I understand that my child care services with BabyFe will be terminated. I also agree to pay all costs and expenses including, without limitation, court costs and reasonable attorney fees incurred by BabyFe in connection with the collection of tuition and the enforcement of this agreement.

________________________________ ________________________ ________________

Parent/Guardian Full name Parent/Guardian Signature Date

________________________________ ________________________ ________________

Parent/Guardian Full name Parent/Guardian Signature Date

Hold Harmless Agreement

I _________________________ *(please print name),* the parent/guardian of ________________________ agree to release and hold harmless BabyFe Bilingual Learning Center and its employees, from any accident or harm that may occur should I retain the services of any BabyFe's employee for the care of my child(ren) outside the child care center. If I retain the services of any BabyFe's employee in such capacity, BabyFe has no responsibility and is held harmless from any incident which may occur.

_______________________________	________________________	________________
Parent/Guardian Full name	Parent/Guardian Signature	Date

_______________________________	________________________	________________
Parent/Guardian Full name	Parent/Guardian Signature	Date

Identity Verification

FOR OFFICE USE ONLY

Place of Birth: ____ Birth Date: ________________________

Birth Certificate Number: ________________________________ Date Issued: ________________________

Other Form of Proof: ____

Viewed by:____ Date viewed:________________________

BabyFe Policies

1. I understand that my child must not be left on school grounds without supervision. I agree to only release my child to a teacher before leaving my child.
2. I understand that all required forms must be completed and on file at the center before my child may attend.
3. I understand that no child may be released to anyone except parents/guardians without written permission. I understand that BabyFe will release children to either parent unless a court order indicating sole custody is provided to the center Director. I agree to give to the center a list of all persons authorized to pick up my child.
4. I understand that any medication will be administered without the Medication Administration Form.
5. I agree to support and reinforce the school's rules and procedures that concern the health and safety of my child and other children.
6. I understand that the Director will notify me whenever my child becomes ill and I agree to pick-up my

child or make arrangements to have my child picked up by an authorized individual within one hour of notification.

7. I understand that my child cannot attend the daycare if he/she has any illness that threatens the health of other children. I understand that Health Department regulations concerning periods of infection will be enforced. I understand that my child must be fever and symptom free for 24 hours before returning to school after an illness. I also understand that prescription medication must be administered to my child at home for 24 hours before he or she can return to the Center.

8. I understand that I am required to inform the center within 24 hours or the next business day if my child or any member of my immediate household has developed any reportable communicable disease, as defined by the OCC, except for life threatening diseases which must be reported immediately.

9. I understand that child care services may be terminated for any of the following reasons:

-My child's tuition account becomes more than two weeks in arrears.

-Failure to respond in a timely manner when contacted by the center to pick up my child when he/she is sick.

-Failure to adhere to the 24 hour illness recuperation period.

-Failure to provide the center with up-to-date emergency contact information for my child.

-BabyFe does not receive parental support and help if my child is found to have a learning or behavioral problem. This includes failure to attend parent conferences and to follow through with medical and/or educational specialists.

-My child's behavior pattern threatens his or her own health and safety or threatens the health and safety of other children and staff.

-Parents/guardians are no longer supportive of BabyFe's program and Philosophy and become negative and uncooperative in their actions and opinion which may undermine the operation of the center.

-Parents who are repeatedly late will be asked to make other child care arrangements.

10. I understand that to ensure my child's spot I have to make weekly payments before the week starts, payments must be made even if the child does not attend BabyFe to ensure the Spot, either for reasons of illness, vacation, rest, due to the weather, due to days that BabyFe closes due to the annual calendar, due to any situation of non-attendance of my child, I understand that payments must be made in the normal way before the week starts to ensure my child's spot, I understand that if I do not pay I will have a fine and my spot can be given to another family.

Please Read and Sign:

I have read the policies in the BabyFe Parent Handbook and understand their application to me and my child.

Mother/Guardian Signature ____________________________________ Date ____________________

Father/Guardian Signature ____________________________________ Date ____________________

Director's Signature ____ Date ____________________

TUITION AGREEMENT

Please note that the tuition chart reflects the upcoming Daycare years' weekly rates. Accordingly, listed below are the tuition amounts due for your family. These rates will be effective September, 2021.

Child Name	Class	Chosen Tuition Amount $	Daily attendance hours	Total$
			10% weekly discount	

Note: The 10% weekly discount only applies to the oldest sibling.

I, ___________________________________(full name) received and read the tuition fees and agree to pay every Friday before the week starts.

I read and understood points number 6 and 15, I agree with all the charges mentioned in the handbook.

____ ____________________________

Parent's signature Date

____ ____________________________

Parent's signature Date

____ ____________________________

Director's Signature Date

The Center Director will sign after reviewing the choice of tuition and amounts.

INFANTS FEEDING & NAP INFORMATION FORM

Child's Name______________________________ Start Date ______________ Age on start date_____________

FORMULA/BREAST MILK INFORMATION

______ Breast milk   _______Formula   Name of formula:________________________________

How should the formula be served? _____ Cold   _____ Warm

Note: Licensing standards will only allow for formula/breast milk to be warmed one time.

FOOD ALLERGIES AND SYMPTOMS

Is the child now, or has the child ever been, treated by a physician for allergies? _____________________________________

When and for how long? ____

Foods that are NOT to be served: ____

Familiar foods that contain the ingredient not to be served: ____
____

Reactions of child when these foods are eaten: ____
____

FEEDING SCHEDULE

Please indicate below your baby's current feeding and nap schedule at home. Please know that BabyFe may not be able to follow this schedule strictly depending on the established schedule to go out to the playground.

Hours	Bottles (Oz amount)	Kinds of Foods & Amount (Cereal/Baby Food)
For example: 8:15am *9:30am* *11:30am*	*1st bottle 5 Oz* *2nd bottle 4 Oz*	First or second fruit tapper *(food brought from home)*

NAP SCHEDULE

NAPS	SPECIFIC HOURS			HOW LONG
For example: Nap time	**From:** *9:00am*	**To:** *10:30am*		*60 - 90 minute mid-morning nap*
1st Nap time	**From:**	**To:**	**OR**	
2nd Nap time	**From:**	**To:**		

My baby does not have a regular nap schedule☐   He/she is sleeping on demand☐

Parent name's and signature ____________________________/_______________________   Date _________________

Parent name's and signature ____________________________/_______________________   Date _________________

NAPPING/FEEDING AGREEMENT

I____(parent's name) agree that my child ____(child's name),

Check if you agree:

☐ I authorize my child to sleep/rest twice a day in Infants and Cruisers, once a day in Juniors and PreK. My child will sleep on a tot cot from 12 months and up, as required by the OCC.

Sleeping arrangements for all BabyFe children require that children be laid on their backs to sleep, unless the parent provides the provider with medical information that demonstrates that this arrangement is inappropriate for that child.

☐ I agree with the schedules of the three daily meals from Cruisers and with the BabyFe menu.

If you do not mark that you agree with the menu, please specify_______________________________

____

____

If you do not agree because your child is allergic to a food, please bring a Medication Administration Authorization Form and the medication, please check the following box if applicable,

☐ I will bring food to my child.

If you are bringing your child food please write on each food container what type of food it is (breakfast, lunch, snack) the date, the child's full name and the classroom, food that is not properly labeled with all of the above information will not be accepted.

Parent's signature____ Date________________

Parent's signature____ Date________________

DIAPER CREAM/INSECT REPELLENT/SUNSCREEN AUTHORIZATION FORM

Child's name:____

I,_________________________________(full name) authorize the application of:

☐ Diaper cream

☐ Insect repellent

☐ Sunscreen

Diaper cream / Insect repellent / Sunscreen are optional use products which I will provide in its original container and labeled with my child's name.

Diaper cream brand:_________________________ Expiration Date:___________

Insect repellent brand:_______________________ Expiration Date:___________

Sunscreen brand:____________________________ Expiration Date:___________

Specific way to apply diaper cream?

☐ No

☐ Yes, (explain in detail)____

____

____

Parent's signature___________________________________ Date_____________

Parent's Signature:____________________________________ Date:___________

PARENT TOILET TRAINING PLAN

From Cruisers

Child's Name:____ Date:____________

The first steps towards toilet training should begin at home on weekends when parents are able to devote the weekend to helping their child. It is suggested that when your child is displaying signs of readiness and he/she is successful at home for a full weekend, then they can begin toilet training at BabyFe. We are here to work with you and your child during this process and a consistent approach at home will lead to successful toilet training at daycare. We offer positive feedback, praise, and class recognition as rewards to motivate your child. The biggest motivator is usually parent encouragement and approval.

Please answer the following questions which will help us during this process:

1. Has your child been successful toilet training at home?

☐ Yes

☐ No

(Successful is defined as child has been accident free for a full week)
If you marked "yes" the teachers will begin toilet training your child. Please remember it is imperative to be consistent at home and at daycare to ensure successful training.
If you marked "no" please know that we will not attempt to start the toilet training process until you indicate otherwise.

During toilet training please follow the guidelines listed below:

- Your child must wear loose fitting clothing that is easy for the child to pull up and down.
- Children should wear Pull-Ups with Velcro easy open sides when starting toilet training. Your child will be in a pull-up during the day and during nap time until we see that he/she has shown that they can stay dry. Children will not be permitted to wear underwear until they have been accident free at daycare for two full weeks. Parents must keep a supply of Pull-Ups at BabyFe.
- Training can be a long process for some children, so patience and understanding is important. Accidents happen in the initial stages, so we request that you provide us with at least 3 sets of underwear, pants/shorts and an extra pair of shoes every day the teacher requires until your child is toilet trained.
- If your child is a boy, please let us know if your child will be sitting or standing to urinate. It is recommended that boys first learn to sit to urinate and once they are consistent, they can be taught to stand and go. This will also lessen problems with learning to put bowel movements in the toilet.

☐ Sitting. ☐ Standing.

A child is considered toilet trained when he/she can independently: recognize the need to use the bathroom; manage his/her own clothing (pull pants and underwear down and up; wipe his/her own bottom and flush toilet; operate faucet to wash his/her hands with soap and water and dry their hands; change his/her soiled clothing when an accident occurs).

We look forward to working with you and your child during this exciting transition to becoming a "big boy or big girl"!

Parent's signature____ Date________________

Parent's signature____ Date________________

LETTER OF A COMPLETE POTTY TRAINING

Dear parents,

At BabyFe we are prepared to help you in the potty training process from the Cruiser class, which is the class of children who are around 18 months to two years old. We have a small bathroom in the classroom to start helping you with this process when you are ready to do so. I trust that everybody is working on this important milestone.
Each child entering the 3 year old class (PreK) must be fully toilet trained by the first day of classes.

A **fully potty** trained child is a child who can do the following:
1. Be able to identify when they have to go "pee" or "poop" and communicate this to a teacher by TELLING them they have to go potty BEFORE they have to go. They have to be able to say the words "I have to go potty".
2. Be able to pull down their underwear and pants and get them back up without assistance.
3. Be able to wipe themselves independently after using the toilet.
4. Be able to get off the potty by themselves.
5. Be able to wash and dry your hands.
6. Be able to take naps in regular underwear without accidents.
7. Be able to postpone going if they must wait for someone who is in the bathroom.

As stated in our Parent Handbook (12.5 Potty training), if your child has not met this milestone parents will be required to keep their child home until this expectation has been met.

Please remember that our PreK classroom is not equipped with a changing table.

Thank you in advance for helping your child stay on track! Best regards,

Juanita Castro Avaroma

Child Care Center Director

SPLASH PERMISSION FORM

I,____, give my permission for my child, ____ (child's name), to play with water in the daycare playground some days in July and August as long as my child is enrolled in BabyFe Bilingual Learning Center.

I understand that the teacher will let me know through Brightwheel one week in advance when the assigned days of the week that my child's class will play with water will be.

*On the day assigned to play with water, I must bring my child with water shoes (that are safe and do not come off when walking), towel, appropriate clothing to play with water and in her/his backpack bring a change of shoes and a complete set of clothes to put on after playing.

____ _____________________________

Parent's Signature Date

____ _____________________________

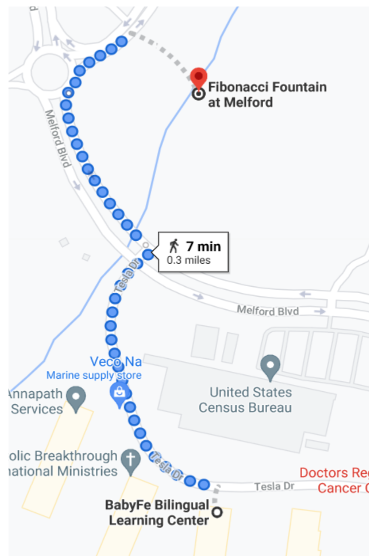
Parent's Signature Date

PERMISSION FOR PICNICS IN THE PARK

I, ____ (full name) give my permission for BabyFe Bilingual Learning Center to take my child,____________________________________ (child's name), to the park in front of the facility, Fibonacci Fountain at Melford, during the months of July and August while my child attends the Center.

I understand that the teachers will communicate to me through Brightwheel a week before to prepare food for the picnic that my son will have with his class, the teacher will give indications of the appropriate menu. I also understand that if I do not want my child to participate in picnics, the child must stay at home since the teachers will be with the whole group.

*I will provide my child with a ready-to-eat lunch and drink from home on these picnics days. My child's disposable lunch bag will be labeled with his/her full name, classroom, and date prepared. **Any kinds of peanuts - tree nuts or glass containers are not permitted!**



Parent's signature____ Date________________

Parent's signature____ Date________________

PHOTO RELEASE

For good and valuable consideration, the receipt of which is hereby acknowledged, **I, ______________________________, hereby grant BabyFe, LLC permission to use my likeness**

Parent's Name

and that of my child, ____________________________, in a photograph and/or video

Child's Name

recording in the publication(s) indicated below. I understand and agree that any photograph and or video recording using our likeness will become property of BabyFe, LLC and will not be returned.

I acknowledge that since my participation with BabyFe, LLC is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize BabyFe, LLC to edit, alter, copy, exhibit, publish or distribute this photo and/or video recording for purposes of publicizing BabyFe, LLC's programs or for any other related, lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein our likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph and/or video.

I hereby hold harmless and release and forever discharge BabyFe, LLC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

[Signature Page to Follow]

☐ I DO NOT give BabyFe, LLC the permission to use video or photography of myself or my child in any publications

☐ I ONLY give BabyFe, LLC permission to use videos and/or photos of myself and/or my child in the BrightWheel application which can only be viewed by other BabyFe, LLC parents.

☐ I give BabyFe, LLC permission to use videos and/or photos of myself and/or my child in ALL of BabyFe, LLC's printed and digital publications including, but not limited to, its social media and website platforms.

Printed Name: ________________________________ Date:________________________

Signature: ____________________________________

For questions, concerns or to file a complaint contact your regional office

Region	Phone
Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worchester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

Resources

Child Care Subsidy - Assists parents with cost of childcare

1-866-243-8796

Consumer Product Safety Commission (CPSC) - regulates certain products used in childcare

cpsc.org

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org

Larry Hogan, Governor

Mohammed Choudhury

State Superintendent of Schools

OCC 1524 (10/2018)

Guide to Regulated Child Care

Important Information About Child Care Facilities

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's (OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary.

COMAR Regulations and other information about the Office of Child Care may be found at:

earlychildhood.marylandpublicschools.org/child-care-providers/office-child-care

What are the types of Child Care Facilities?

Family Child Care – care in a provider's home for up to eight (8) children

Large Family Child Care– care in a provider's home for 9-12 children

Child Care Center – non-residential care

Letter of Compliance (LOC) – care in a child care center operated by a religious organization for children who attend their school

All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

Did You Know?

- Regulations that govern child care facilities may be found at: earlychildhood.marylandpublicschools.org/regulations
- The provider's license or registration must be posted in a conspicuous place in the facility;
- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;
- Parents/guardians may visit the facility without prior notification any time their children are present;
- Written permission from parents/guardians is required for children to participate in any and all off property activities;
- All child care facilities must make reasonable accommodations for children with special needs;
- A "Teacher" qualified person must be assigned to each group of children in a child care center;
- Staff:child ratios must be maintained at all times in child care centers;
- Parents/guardian must be immediately notified if children are injured or have an accident in care;
- Child care facilities may have policies beyond regulatory requirements;
- OCC should be notified if a provider has violated child care regulations;
- Parents/guardians may review the public portion of a licensing file; and
- The provider's compliance history may be reviewed on CheckCCMD.org.

I,______________________________________(parent's name), received the Guide to Regulated Child Care.

____________________ Child's Name

____________________ Parent's Signature

____________________ Date