



Thank you for registering!

Please complete the attached forms, paying close attention to the forms that must be completed by the PARENT/GUARDIAN or the PHYSICIAN. Important areas (areas families tend to miss) have been highlighted for your convenience.

ALL participants (regardless of AGE OR GRADE) must complete ALL forms, per licensing regulations. No exceptions. Please fill in all forms ENTIRELY.

All forms must be turned in prior to June 1. You may email them to Janelle Schmidt [jschmidt@harfordday.org](mailto:jschmidt@harfordday.org), drop them off at the main office of the school between 9am-2pm, or bring them to the Early Childhood building between 3:30-5:30pm. It is required that the Director has them BEFORE the first day.

Families new to Summer smARTS or Harford Day School must turn in forms 1 through 7.

Families who attended Harford Day this past school year, or who are returning Summer smARTS families, only need to complete forms 5, 6, and 7, unless your medical situation has changed (i.e. updated vaccines).

Only children with the following conditions need to complete the relevant attached forms:

- Asthma
- Allergies and anaphylaxis
- Medicine required to be administered at camp
- Any individualized treatment plan
- Seizure/epilepsy/convulsion disorder

Please let Janelle Schmidt know if you have any questions:

[jschmidt@harfordday.org](mailto:jschmidt@harfordday.org)

410-809-2390

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

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex  M  F

Address: \_\_\_\_\_  
 Last First Middle Mo / Day / Yr

Number Street Apt# City State Zip

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

<b>Medical Care Provider</b> Name: Address: Phone:	<b>Health Care Specialist</b> Name: Address: Phone:	<b>Dental Care Provider</b> Name: Address: Phone:	<b>Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child Care Scholarship</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Last Time Child Seen for Physical Exam:</b> <b>Dental Care Specialist:</b>
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**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	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	
Autism Spectrum Disorder	<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"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory Impairment	<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"/>	
Vision	<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? 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 \_\_\_\_\_

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

<b>Child's Name:</b>	<b>Birth Date:</b>	<b>Sex</b>
Last                      First                      Middle	Month / Day / Year	M <input type="checkbox"/> F <input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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:
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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

Table with 14 columns: Dose #, DTP-DTaP-DT, Polio, Hib, Hep B, PCV, Rotavirus, MCV, HPV, Hep A, MMR, Varicella, Varicella Disease, COVID-19. Rows 1-5 for vaccine administration tracking.

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

Clinic / Office Name
Office Address/ Phone Number

1. Signature Title Date
2. Signature Title Date
3. Signature Title Date

Empty box for Clinic / Office Name and Address/Phone Number.

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

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS.

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: Medical Provider / LHD Official Date

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.

Signed: Date:

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MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

ALL

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

Table with 4 columns: Test Date, Type (V=venous, C=capillary), Result (mcg/dL), Comments. Rows contain 'Make a selection:'.

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:

CACFP Enrollment: Yes:  No:

Meals your child will receive while in care:

BK  LN  SU  AM Snk  PM Snk  Evng Snk

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**EMERGENCY FORM**

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (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	Contact Information		
		Email:	C:	W:
			H:	Employer:
		Email:	C:	W:
			H:	Employer:

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 \_\_\_\_\_

6) if not, strike thru

**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



complete it needed  
discard if not

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)		2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____		3. Child's picture (optional)		
<b>Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER</b>						
4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ____%						
5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____						
6. This authorization is NOT TO EXCEED 1 YEAR FROM ____/____/____ TO ____/____/____ FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216						
<b>GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated</b>						
The Child has <u>ALL</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night if known, peak flow greater than _____ (80% personal best)						
<b>Exercise Zone</b> <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it						
<b>YELLOW ZONE - GETTING WORSE</b> <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____						
The Child has <u>ANY</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ if known, peak flow between _____ and _____ (50% to 79% personal best)						
<b>RED ZONE - MEDICAL ALERT/DANGER</b> <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____						
The Child has <u>ANY</u> of these		Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ if known, peak flow below _____ (0% to 49% personal best)						

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

CHILD'S NAME (First Middle Last) \_\_\_\_\_ DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER**

8. PRESCRIBER'S NAME/TITLE \_\_\_\_\_ Place Stamp Here

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)  
(original signature or signature stamp only) \_\_\_\_\_

9b. DATE (mm/dd/yyyy) \_\_\_\_\_

**Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN**

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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 childcare 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 childcare 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

10a. PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ 10b. DATE (mm/dd/yyyy) \_\_\_\_\_ 10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION \_\_\_\_\_

10d. CELL PHONE # \_\_\_\_\_ 10e. HOME PHONE # \_\_\_\_\_ 10f. WORK PHONE # \_\_\_\_\_

Emergency Contact(s) Name/Relationship \_\_\_\_\_ Phone Number to be used in case of Emergency \_\_\_\_\_

Parent/Guardian 1 \_\_\_\_\_

Parent/Guardian 2 \_\_\_\_\_

Emergency 1 \_\_\_\_\_

Emergency 2 \_\_\_\_\_

**Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM**

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

4. OCC 1215 Health inventory updated  Yes  No

5. Modified Diet/Exercise Plan  Yes  No  N/A

6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP  Yes  No  N/A

7. Staff approved to administer medication is available onsite, field trips  Yes  No

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

complete it needed  
discard if not

Complete as needed  
discard if not

**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	
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 _____               | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
| 2. Medication labeled as required by COMAR.                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
| 3. OCC 1214 Emergency Form updated.   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 4. OCC 1215 Health Inventory updated.                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP.         | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 6. Staff approved to administer medication is available onsite, field trips | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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complete as required  
discard if not

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

**Individualized Treatment/Care Plan Checklist for Specialized Services**

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

Condition that requires Specialized Care: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSTRUCTIONS:** Parents and child care providers should review and sign this form when enrolling a child with special health care needs and/or individualized treatment care plans, procedures, or medications. Attach this form to the child's treatment/care plan. The second page can be used for documentation of care, procedures, and/or medications that are not documented on any other form.

**IF A MEDICAL TREATMENT PLAN INCLUDES A MEDICATION, IS SIGNED BY THE HEALTH CARE PROVIDER, AND IS ATTACHED TO THIS FORM THEN OCC 1216 IS NOT REQUIRED. For example, for diabetes medications, child care providers may accept the Diabetes Medical Management Plan.**

	Items	Received & Reviewed			Parent Initial	Child Care Staff Initial
		Yes	No	N/A		
1	A written individualized care/treatment plan, signed by a certified professional and the parent, has been provided to the child care provider.					
2	Each staff member providing care to a child is trained, by licensed/certified professionals, in the use of specialized health care procedures or equipment. Trainer's Name & Credential: _____ Training Date: _____ Name of all staff who were trained: _____					
3	Provider agrees to allow a parent-approved adult who provides specialized services to a child in care to provide those services on the facility premises as specified in the child's individualized education or healthcare plan.					
4	Updated Emergency Form (OCC 1214).					
5	Updated Health Inventory Form (OCC 1215).					
6	Modified Menu Plan received, if applicable.					
7	Modified Physical Activity Schedule received, if applicable.					
8	Trained staff or parents are available for field trips /off-site activities.					
9	Medical Bracelet /Medical Alert Badge.					
10	Individualized Treatment/Care Plan: medical/behavioral plan/IEP/IFSP.					

**PARENT/GUARDIAN AUTHORIZATION:** I/We request the child care program to provide the care indicated above. I certify that I have the legal authority, understand the risks, and authorize the trained childcare staff to provide care as per the Instructions for the child named above. I agree to review and demonstrate special procedures and arrange for a certified professional to train the staff for my child's specific care components. I agree to provide the child care program with any significant updates to the child's health care condition or treatment plan. I authorize the childcare staff and the healthcare professional indicated on this form to communicate in compliance with HIPAA.

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

Phone # \_\_\_\_\_ Emergency Contact Phone #: \_\_\_\_\_

Child Care Staff Signature \_\_\_\_\_ Date: \_\_\_\_\_

SEE PAGE 2 FOR DOCUMENTATION ON LOG



complete - if received  
discard if not

MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure/Convulsion/Epilepsy Disorder  
Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
Page 1 is to be completed by the authorized Health Care Provider.  
FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

Place Child's  
Picture Here  
(Optional)

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Plan: \_\_\_\_\_

Significant Medical/Health History: \_\_\_\_\_

Seizure Triggers or Warning Signs: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Seizure Care Information**

Seizure Type	Length (duration)	Frequency	Description

**Seizure Emergency Protocol:** How to respond to a seizure (Check all that apply)

- First Aid – Stay. Safe. Side (refer to resource document “Seizure First Aid Guide”)
- Call 911 for transport to \_\_\_\_\_  Notify parent or emergency contact
- Notify Health Care Provider \_\_\_\_\_  Other \_\_\_\_\_
- Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

**Care after seizure:** Does the child need to leave the classroom after a seizure?  Yes  No

What type of help is needed? (describe) \_\_\_\_\_

When can the child return to care/resume regular activity? \_\_\_\_\_

Special Considerations and Precautions (regarding activities, sports, trips, etc.) \_\_\_\_\_

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only)		DATE (mm/dd/yyyy)



complete in red  
discard if not

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

Place Child's Picture  
Here (optional)

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
**Page 1 to be completed by the Authorized Health Care Provider.**  
**FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216**

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of plan: \_\_\_\_\_  
Child has Allergy to \_\_\_\_\_  Ingestion/Mouth  Inhalation  Skin Contact  Sting  Other \_\_\_\_\_  
Child has had anaphylaxis:  Yes  No  
Child has asthma:  Yes  No (If yes, higher chance severe reaction) Child  
may self-carry medication:  Yes  No  
Child may self-administer medication:  Yes  No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
<b>is Not exhibiting or complaining of any symptoms, OR</b>		
<b>Exhibits or complains of any symptoms below:</b>		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Throat*:</b> difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
<b>Lung*:</b> shortness of breath, repetitive coughing, wheezing		
<b>Heart*:</b> weak or fast pulse, low blood pressure, fainting, pale, blueness		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Other:</b>		
<b>If reaction is progressing (several of the above areas affected)</b>		

\*Potentially life threatening. The severity of symptoms can quickly change\*

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.**
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.**
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.**
- 5) Give other medicine, if prescribed.**

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		

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

complete if needed  
discard if not

Maryland State Department of Education  
Office of Child Care

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

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

PARENT/GUARDIAN AUTHORIZATION			
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have 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.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #	
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. OCC 1214 Emergency Card updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	6. Individualized Plan: IEP/IFSP	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
	7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE