MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:___ No:___

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. 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: H:	W: Employer:
		Email:	C: H:	W: 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 ______________

OCC 1214 (Revised 01/2022) - *All previous editions are obsolete.*

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

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

GRACE CLASSICAL ACADEMY
EST. 2011

Emergency Contact Form

PLEASE FILL OUT ONE FORM PER FAMILY (INCLUDE ALL ENROLLED CHILDREN)

Child's Full Name (First, Middle, Last)________________________________ Birth Date ____/_____/________

Child's Full Name (First, Middle, Last)________________________________ Birth Date ____/_____/________

Child's Full Name (First, Middle, Last)________________________________ Birth Date ____/_____/________

Child's Full Name (First, Middle, Last)________________________________ Birth Date ____/_____/________

Child(ren)'s Home Address: ____

Street/Apt. # City State Zip Code

Parent/Guardian Name(s):	Relationship:	Phone Numbers:		
		Work:	Cell:	Home:
		Work:	Cell:	Home:
		Work:	Cell:	Home:
		Work:	Cell:	Home:

Name of person(s) (other than parents) authorized to pick up child(ren) or who can be contacted in case of emergency:

Name: ____________________________ Relationship: ____________ Phone: ______________________

Name: ____________________________ Relationship: ____________ Phone: ______________________

Name: ____________________________ Relationship: ____________ Phone: ______________________

Name: ____________________________ Relationship: ____________ Phone: ______________________

Child's Physician: ____________________________ **Phone:** ____________________________________

Address:____

Street/Apt. # City State Zip Code

In an EMERGENCY requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes Grace Classical Academy and its representatives to transport your child and give consent to obtain emergency medical treatment in case of any illness or injury in connection with a school activity or school trip. Such treatment will be administered by physicians, other medical personnel, hospitals, and/or clinics selected by Grace Classical Academy or its representatives.

Signature of Parent/Guardian ____ **Date** ______/_______/__________

2416 Creswell Road Bel Air, MD 21015 / 410-734-6111
www.graceclassicalMD.org/office@graceclassicalMD.org

GRACE CLASSICAL ACADEMY
EST. 2011

Field Trip Policies and Car Seat Form

- Chapel uniforms are required for all field trips.
- Students must be accompanied by an adult/chaperone at all times while on a field trip.
- Students must respectfully obey all teachers/parents/chaperones/tour guides.
- Students under 13 years of age should be seated in back seats and use the required car seat/booster seat and seatbelts as required by Maryland law.
- Electronics are NOT permitted on field trips; including cell phones, iPods, tablets, hand-held games, and in-car DVD players. Parents are asked not to show movies while traveling to and from field trips as parental standards differ.
- Parents must provide medication from home for children needing medication during a field trip. Medication already in the office cannot travel on field trips. If a student requires medication during the field trip, a parent must attend unless an adult with medication administration training is able to go on the trip.

PLEASE FILL OUT, SIGN AND RETURN THIS FORM TO THE SCHOOL OFFICE

****

We have read and will support all GCA field trip policies:

______________________________ ______________________

(Signature) father / guardian (date)

______________________________ ______________________

(Signature) mother / guardian (date)

****

Student Car Seat Information

The following child(ren) is/are required to be in a car or booster seat and parents will be responsible for sending one to school for field trips if not driving. (The seats may be dropped off to the student's classroom the morning of the trip.)

Student(s) Name(s) ____

____

Age(s) & Grade(s) ____

____

GRACE
EST. 2011
CLASSICAL ACADEMY

Driver Insurance Form – Field Trips and Athletics

Name of Family:____

☐ Please check here if you are ARE available to drive for field trips or school events and sign below to attest that the below information is true (all information will be kept confidential).

__________________________ ________________________
(signature) father / guardian (date)

__________________________ ________________________
(signature) mother / guardian (date)

☐ Please check here if you ARE NOT available to drive for field trips or athletic events.

*Please note – parents are responsible for arranging transportation for their children to and from athletic practices and games.

*This form must be completed in full for you to be able to drive other students for field trips and school events. Our insurance company requires this information to be on file for all drivers.

	(Father's info)	(Mother's info)
Parent / Guardian Name		
Driver's License Number		
Vehicle License Plate Number		
Vehicle Make & Model		
Name of Insurance Provider		

(Check One)

Policy Number: ________________________ Is the policy current? ___YES / ___NO

Have you ever committed or been charged with any criminal offenses? ___YES / ___NO
*If yes, please explain:

Have you ever had a problem with substance abuse or alcohol abuse? ___YES / ___NO
*If yes, please explain:

In the past 12 months have you received a citation for any moving violations? ___YES / ___NO
*If yes, please explain:

In the past 12 months have you been the driver of a vehicle that has been in an accident? ___YES / ___NO
*If yes, please explain:

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www.graceclassicalMD.org/office@graceclassicalMD.org

Parent Volunteer Form

Family Last Name ______________________________

The community at Grace Classical Academy is growing and thriving because of the dedication and commitment of parents. In classical education, "parents are welcome in the classroom; it means that parents take their responsibility seriously be reviewing and helping with homework, encouraging their child to be disciplined and diligent, and generally supporting teachers and staff of the school." (*An Introduction to Classical Education* by Christopher A. Perrin, MDiv, PhD. Page 35.)

With that in mind, we ask each family to volunteer in at least one of the ways listed below. Please look at the volunteer opportunities and descriptions below and write a 1, 2, or 3 beside your first, second, and third choice for a Parent Volunteer Job.

If applicable, please share how your family met their volunteer obligation last year:

_____ **Recess Duty – our greatest need**
One volunteer is needed each day from 12:00pm to 12:30pm (approximately) for grades 1 to 6 to monitor the students during their recess before lunch. This time allows teachers to eat their own lunch, reset for the afternoon, and take care of other important responsibilities. Volunteers commit for a minimum of one academic quarter of the school year. Please select your preferred quarter and day of the week

Q1 _____ Q2 _____ Q3 _____ Q4 _____
M _____ T _____ W _____ Th _____ F _____

_____ **Carpool Recorder**
One or two volunteers are needed each day from 3:15pm to 3:45pm to assist with carpool pickup. Volunteers write down the last names of the students whose parents are in the carpool line. Volunteers commit for a minimum of one academic quarter of the school year. Please select your preferred quarter and day of the week

Q1 _____ Q2 _____ Q3 _____ Q4 _____
M _____ T _____ W _____ Th _____ F _____

_____ **Classroom Moms**
With the guidance and help of the teacher, Room Moms plan the classroom parties and serve as a communication liaison between Grace Classical Academy and the class parents. Room Moms are required to attend the Room Mom Meetings held in the library on the third Thursday / Friday of each month September through June. Please select the grade(s) you would like to serve as a Room Mom:

Pre-K 3 _____ 1 _____ 4 _____ 7 _____ 10 _____
Pre-K 4 _____ 2 _____ 5 _____ 8 _____ 11 _____
K _____ 3 _____ 6 _____ 9 _____ 12 _____

_____ **Lunch Helpers**
One volunteer is needed Monday through Thursday from 12:15pm to 12:45pm to distribute school lunches. Volunteers commit for a minimum of one academic quarter of the school year. Please select your preferred quarter and day of the week

Q1	_______	Q2	_______	Q3	_______	Q4	_______
M	_______	T	_______	W	_______	Th	_______

_____ **Open House Volunteers**
Open Houses are held a few times a year during a weekday morning, weekday evening at 6:45pm, or a Saturday morning at 10:00am. Please indicate your preferred time
Morning _______ Evening _______ Weekend _______

_____ **Special Event Volunteers**
Under the leadership of the GCA Events Coordinator, assist with setting up and/or cleaning up various school events such as the Science Fair, Upper School Dances, Field Day, Homecoming, Graduation, etc.

_____ **Art Program Volunteers**
In the days and weeks leading up the Spring Music and Art Program, assist with mounting the artwork and hanging projects on the walls

_____ **Facilities Volunteers**
On an as-needed basis, assist with small projects at school requiring basic carpentry skills such as hanging shelves, pictures, assembling furniture, etc.

_____ **Landscaping Volunteers**
Maintain flowerbeds and outdoor areas. This job **does not** include mowing and snow shoveling/plowing

_____ **Consignment Closet Volunteers**
Once a month, sort and organize school uniforms that have been donated back to Grace Classical Academy

Committee Involvement
There is a need for leadership and/or participation on the following committees. Please indicate if you would like to lead or serve on these committees by placing an "L" (lead) or "S" (serve)

Athletic Teams (coaching)	_______	Food Prep for Special Events	_______	Parent Prayer Team	_______
Booster Club	_______	New Family Welcome	_______	Yearbook	_______

Grace Classical Academy School Health and Medication Policy

For the safety of our students Grace Classical Academy requires the following:

A current copy of each student's Immunization Record (must be current/updated with each new vaccine). The school can provide a copy of this form or you may request it from your child's physician. Harford County Health Department makes regular audits to be sure all students are in compliance. If your child receives any new immunizations please provide the school with an updated copy.

Record of Physical Examination/Health Assessment (each student must have one on file). This is a two part form; Part 1 is to be filled out by the parent/legal guardian and Part 2 is to be filled out and signed by the student's physician.

Any medication that a student may need during the school year, whether prescription or over the counter (ie: Tylenol, Advil, allergy medication, eye drops, cough/cold medication, itch/rash cream, etc.) must be brought to the school office by the parent to be signed for. (Medication may not be sent with the student.) Over the counter medication must be in the original packaging marked with the student's name and grade on the package. Prescription medications must be in the original pharmacy issued container labeled with the student's name and dosage printed on it. ALL medications above MUST be accompanied by the *Maryland State School Medication Administration Authorization Form* (provided by the school or your child's physician). We are not permitted to dispense any medication to your child without the completed form. If you think your child will be in need of any sort of over the counter medications throughout the school year, it's best to ask their physician at their annual check-up to fill out the forms for you and send them to school with those medications in the beginning of the school year so they will be on hand for your student, as we are not permitted to dispense any medication without the authorization form and your provided medication. Please do not combine medications on the form, fill out one form per medication. All medications are kept safely locked in the school office as per the regulations set forth by the Maryland State Health Department.

*Cough drops and suntan lotion are the only exception to over the counter medications, but we do require a note from the parent to be sent in along with the cough drops/lotion in their original package marked with your student's name and grade. Students are not permitted to share suntan lotion due to allergies.

Epi- Pens and Inhalers:

Any student that requires an epi-pen or an asthma inhaler is required by the Maryland State Health Department to submit their "Allergy Action Plan" (epi-pens)/ "Asthma Action Plan"(inhalers) from their child's doctor in addition to the Medication Administration Authorization Form. We are not permitted to dispense either of the above without the Action Plan Form. If a student is to self-carry an epi pen or inhaler it must be documented by the child's doctor on the form and agreed upon by the school administration that the child is able to responsibly self-carry. If the student dispenses either of the medications above on their own, they must inform the teacher so it can be documented in the school office.

Thank you for your cooperation in complying with the above policies.

GRACE CLASSICAL ACADEMY
EST. 2011

Emergency Medical Information Form

If your child takes medication and/or has a medical condition, this form must be completed in case emergency medical treatment is necessary.

Please fill out one form per child (if applicable).

Child's Name: ______________________________ **Date of Birth:** _____/_____/________

Medications currently taken by your child (prescription or over the counter even if taken at home):

Medication Name:____________________ For:__________ Dosage:__________ Frequency:__________

Medication Name:____________________ For:__________ Dosage:__________ Frequency:__________

Does your child have any allergies? _____ **YES** _____**NO**

If yes, please explain the allergy (medication, food, environmental) ______________________________

____

An Asthma/Allergy Action Plan Form along with the Medication Administration Authorization Form must be completed by your child's Physician.

Does your child have any other medical conditions of which we need to be aware of? ____**YES** ____**NO**

(1) Signs/symptoms to look for: ____

____

(2) If signs/symptoms appear, do this: ____

____

(3) To prevent incidents: ____

____

Parent Signature: ______________________________ ______/________/________

Date

2416 Creswell Road / Bel Air, MD 21015 /410-734-6111/ office@graceclassicalmd.org
[Independent, Non-denominational School certified by MSDE]

Maryland Schools
Record of
Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** *A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement.* (http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** *A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at:* http://www.edcp.org/pdf/DHMH896new.pdf.

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** *The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* http://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a families religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

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

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://www.marylandpublicschools.org/NR/rdonlyres/8D9E900E-13A9-4700-9AA8-5529C5F4C749/3341/medicationform404.pdf. **If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene — Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?

No Yes Name(s) of Medications: ______________________________

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No Yes Treatment ______________________________

Does your child require any special procedures? (catheterization, etc.)

No Yes

Parent/Guardian Signature ______________________________ Date: ______________

PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes ______________________________

   ____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes ______________________________

   ____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No Yes ______________________________
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ______________________________

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

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

(Child's Name) ______________________________________ has had a complete physical examination and has:

9 no evident problem that may affect learning or full school participation 9 problems noted above

____

Additional **Comments:**

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date

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 ______

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1													
2													
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4													
5													

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 Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

Triggers (list)
____
____
____
____
____
____

Student's Name: ______________________ DOB: ______________ PEAK FLOW PERSONAL BEST: ________________

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE: Long Term Control Medication — use daily at home unless otherwise indicated

	Medication	Dose	Route	Frequency
☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: ____________ ☐ Peak flow greater than _______ (80% personal best)				
☐ Prior to exercise/sports/ physical education	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

	Medication	Dose	Route	Frequency
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: ____________				
☐ Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in ______ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

RED ZONE: Emergency Medications — Give these medications and call 911

	Medication	Dose	Route	Frequency
☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Other: ____________ ☐ Peak flow less than __________ (50% personal best)				
	Contact the parent/guardian after calling 911.			

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications: (School-age children) ☐Yes ☐No

Prescriber signature: ________________________ Date: ________ Parent / Guardian Signature: ____________________ Date: ________

Reviewed by Child Care Provider: Name: ______________________ Signature: ________________________ Date: ________

3/20/2014

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) __________________ including the summer session.

School: ____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: __________________ Date of Birth: __________________ Grade: __________

Condition for which medication is being administered: __________________

Medication Name: __________________ Dose: __________________ Route: __________________

Time/frequency of administration: __________________ If PRN, frequency: __________________

If PRN, for what symptoms: __________________

Relevant side effects: ☐ None expected ☐ Specify: __________________

Medication shall be administered from: __________________ to __________________
Month / Day / Year — Month / Day / Year

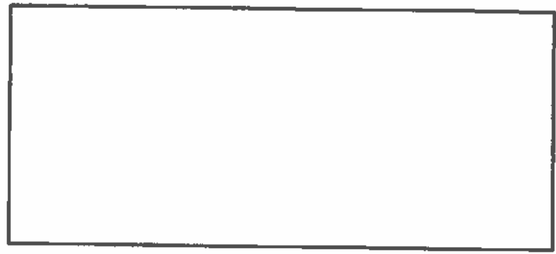
Prescriber's Name/Title: __________________
(Type or print)

Telephone: __________________ FAX: __________________

Address: __________________

____

Prescriber's Signature: __________________ Date: __________
(Original signature or signature stamp ONLY)



(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): __________________ for the above medication on (Date): __________

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: __________________ Date: __________

Home Phone #: __________________ Cell Phone #: __________________ Work Phone #: __________________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: __________________
Signature — Date

School RN approval for self carry/self administration of emergency medication: __________________
Signature — Date

Order reviewed by the school RN: __________________
Signature — Date

2004

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: ______________________ Date of Birth: __________

ALLERGY TO: ______________________

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is *not* exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

______________________ ______________
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:______________________ Phone Number:______________

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

______________________ ______________
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: ______________________________ **Date of Birth:** ______________

ALLERGY TO: ____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food.
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐ ____

____

____

____

____

EPIPEN® userguide

1. Pull off the blue safety release cap.
2. Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.
3. Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

HOLD for 10 seconds

Call 911

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐ ______________________________