Emergency Contact Form

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

School Year: _____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child(ren)'s Home Address: _____
Street/Apt. # **City** **State** **Zip Code**

Parent/Guardian Name(s):	Relationship:	Cell:	Work/Other (specify):	Email:

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** _____/_____/_____

Part 1 Health Assessment

To be completed by parent or guardian

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____ Phone _____

Address (Number, Street, City, State, Zip) _____

_____

Parent / Guardian Names _____

Where do you usually take your child for routine medical care? Phone _____

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 _____

Name _____ Address _____

Assessment of Student Health

To the best of your knowledge, has your child has any problem with the following? Please check and provide comments if yes.

Student Health Issues	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			
Hospitalizations (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			

Part 1 Health Assessment - continued

To be completed by parent or guardian

Does your child take any medication?

No Yes Name(s) of Medications _____

No Yes Treatment _____, etc.

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

No Yes Specify _____

_____ _____

Parent / Guardian Signature Date

Part II – School Health Assessment

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

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____

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?

   No Yes _____

   _____

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		
Muscoskeletal/ Orthopedic				Nutrition		
Neurological				Physical Illness / Impairment		
Skin				Psychosocial		
Endocrine				Speech / Language		
Psychosocial				Vision		
Other				Other		

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

Part II – School Health Assessment - continued

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

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).
   http://test.msde.maryland.gov/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

   No Yes _____

   _____

7. Screenings

Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	
Hearing		
Vision		

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

No evident problem that may affect learning or full school participation _____

Problems noted above _____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____ _____

Physician / Nurse Practitioner (Type or Print) Phone

_____ _____

Physician / Nurse Practitioner (Signature) Date

K - 1st only

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes ◯ No ◯ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes ◯ No ◯ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes ◯ No ◯ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes ◯ No ◯ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes ◯ No ◯ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes ◯ No ◯ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes ◯ No ◯ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: _____

LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	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	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #10
									DOSE #3		DOSE #3	DOSE #3		

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

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)

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? _____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
www.graceclassicalMD.org/office@graceclassicalMD.org

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:

Student Name(s): _____ Grade(s): _____

_____ _____
(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) _____

_____

Driver Insurance Form – Field Trips and Athletics

Name of Family:_____

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

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

	(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:

_____ _____
(Signature) Father / Guardian (Date)

_____ _____
(Signature) Mother / Guardian (Date)

GRACE CLASSICAL ACADEMY EST. 2011

Parent Volunteer Form

Family Last Name _____

The community at Grace Classical Academy is growing and thriving because of the dedication and commitment of parents.

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 choices** for a Parent Volunteer Job.

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

_____ **Recess Duty** – our greatest need
Volunteers needed each day from 12:00pm to 12:30pm (approximately) for grades 1 to 6 to monitor the students during their recess before lunch.
M _____ T _____ W _____ Th _____ F _____

_____ **Carpool Recorder**
Volunteers needed each day from 3:15pm to 3:30pm to assist with carpool pickup. Volunteers write down the last names of the students whose parents are in the carpool line. Please select your preferred day of the week.
M _____ T _____ W _____ Th _____ F _____

_____ **Tablecloth Cleaning**
After events to launder tablecloths.

_____ **Lunch Helpers**
Volunteers needed Monday through Friday from 12:10 pm to 12:30 pm to distribute school lunches.
M _____ T _____ W _____ Th _____ F _____

_____ **Parents Prayer Group**
Meet with other parents to pray for the needs of our school.

_____ **Event Helpers**
Set up / clean up for school events

_____ **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 _____

_____ **Library Volunteers**
Data entry / catalog books

_____ **Art Volunteers**
Help maintain art classroom. Prepare student art work for Spring Art Program. Assist with Square 1 Art Fundraiser.

_____ **Yearbook**
Help guide students on the Yearbook Committee

_____ **Drama Production Volunteers**
Help with sets, costumes and other tasks as needed.

_____ **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. Help organize summer uniform sale.

_____ **Room Parent**
Assist teachers with class special events. Indicate desired grade. Grade: ____

_____ **PTF Fundraiser Help**
Help with annual fundraisers, such as Christmas greens and flower distribution.

Committee Involvement

Please let us know if you would also be interested in serving on a committee. Please indicate if you would like to **lead or serve on these committees by placing an "L" (lead) or "S" (serve).**

_____ **Athletic Teams**
(Coaching, Assistant Coaching, team parent)

_____ **Food Prep for Special Events**

_____ **Booster Club**
(To support Athletics)

_____ **Marketing**
(e.g., help distribute flyers to local businesses)