



OUR COMPLETE 2025-2026 ENROLLMENT PACKET

This packet was last revised on 1/1/2025



Parent/Guardian Acknowledgement of Receipt of Parent Manual

I have received the Legacy Child Development Center **Parent Manual** and I have agreed to read, abide by, and follow the policies set forth therein.

Signature of Parent(s)/Guardian(s)

Printed Name(s)

Date

_____	_____	_____
_____	_____	_____

Children Transport to and from evacuation sites in case of emergency:

In case of an emergency, I give Legacy Child Development Center permission to transport my child in personal vehicles to and from our designated evacuation site. I therefore acknowledge that I have received and read Legacy Child Development Center's Emergency Preparedness Plan.

Yes ___ No ___

If no, please indicate below how you would like your child transported:

Additionally, I would like to volunteer by helping with transporting children to the evacuation site during emergencies.

Yes ___ No ___

If yes, kindly provide us with your best reachable contact number

(_____) _____ - _____ (Type :) Cell ___ Home ___ Work ___

Email Address: _____

Legacy Child Development Center Infant/Toddler Individualized Plan

This plan should be completed with the parent and the teacher before a child starts attending Legacy Child Development Center. It is very important that this plan is updated every 3 months in order for us to provide outstanding services to our families.

Sleeping Patterns:

Eating Patterns:

Changing Patterns:

What does your child like and dislike?

Please list any special request that you would like us to provide for your child.

(Please continue on back if needed.)

Teacher's Signature _____ Date _____

Parent's Signature _____ Date _____

Child's Name _____

2024-2025 Re-Enrollment Agreement

LEGACY CHILD DEVELOPMENT CENTER ENROLLMENT AGREEMENT

TO THE PARENT: Please read this Agreement carefully. If you do not understand any part of it, feel free to ask the Center Director about it. This Agreement and its attachments establish your legal rights and responsibilities, and those of Legacy Child Development Center, regarding your child's participation at Legacy Child Development Center. Throughout this Agreement and attachments, the terms "you" and "parent" refer to the parents or legal guardians of the child enrolled at the Center, and the terms "Center" and "we" refer to Legacy Child Development Center and its staff members. The term "school day" means a day when the Center is open and operating.

By executing this Agreement, You _____,
(Printed names of parents or guardians) agree to enroll your child, _____ at Legacy Child Development Center, and Legacy Child Development Center agrees to accept your child's enrollment, under the terms and conditions as stated below:

1. Program and Hours of Care.

Beginning on the date of _____, 20____, the Center will provide care for your child in the _____ classroom with the following schedule:

Circle hours of care needed (maximum of 10 hours per day): 6:30-4:30 | 7:30-5:30

Other: FROM _____ TO _____ Initials of parent _____ Initials of Director _____

Please do not drop off before contractual agreement due to staff/child ratios that must be maintained in the morning hours prior to the arrival of additional staff.

Note: Children can only be in school for a maximum of 10 hours per day. _____Initial

The fee is an Additional \$25 per week if parent needs more than 10 hours of care. _____Initial

If parent fails to pick up at contractual time, the late fee will automatically be charged to the account that day. Please review late fee policy. _____Initial

2. Payment.

- a. **Tuition.** Tuition for your child will be \$_____ per _____. Your childcare scholarship is current \$_____ therefore your weekly copayment will be _____.

Weekly tuition/co-payment is due each Monday before noon. Monthly tuition is due on the first school day of each month. Part-time tuition is due the first day of your child's enrollment schedule. Weekly tuition is late and is subject to a late fee of \$10.00 per day on Tuesday at noon. Monthly tuition is late on the second school day of the month at noon and is subject to a late fee of \$10.00 per day until paid.

3. Method of Payment.

All tuition payments are made through our automated payment processing, **Tuition Express (See forms Attached)**. Your payment processing may be setup through credit card or bank draft. No other payment methods are accepted. If any automated payment is returned unpaid, you will owe a service fee of \$35.00 in addition to other amounts due. All Credit Cards Payment options will incur a \$2.9%/per week processing fee.

Credit Cards (additional 2.9% per week processing fee) _____ (Initial)

Bank Account (Free) _____ (Initial)

4. Late Fees, Suspension, and Termination for Late Payment.

A late fee of **\$10.00 per school day** will be charged every day by noon if your week's tuition is not paid by the due date as required in the enrollment agreement. The due date for tuition is **Friday**. Your grace period is **Monday by noon**. If the Center has not received your tuition by the due date for your weekly tuition (or by the fifth calendar day of the month for monthly tuition), the Center may refuse to admit your child to the Center until you pay the amount due. The Center also reserves the right to terminate your child's enrollment for non-payment. You hereby agree that, if Legacy Child Development Center, has to take collection action to collect unpaid fees, you will be responsible for all accrued late charges until the date collected, and for reasonable collection costs, including attorney's fees. _____(Initial)

5. Late Pick-Up Penalties.

If your child is picked up after the scheduled closing time of 5:30pm, you will owe a late fee of \$15.00 for up to the first 5 minutes and \$1.00 for each additional minute. These late pick-up penalties must be paid in cash immediately to the office staff. If your child is picked up more than thirty (30) minutes late two (2) or more times in any thirty (30)-day period, the Center may terminate your child's enrollment. _____(Initial)

6. Damage to Center Property.

You hereby agree that you will be responsible for any damage to Center property or equipment caused by you or your child, normal wear and tear excepted, including repairs made necessary by your actions or your child's actions. _____ (Initial)

7. Changes in Tuition.

You understand that tuition rates are subject to change, and you agree that you will pay the new rate after the Center gives you at least thirty (30)-days' notice of such change.

Parents' Signature(s) _____

8. Absences.

You are responsible for paying full tuition for your child until YOU TERMINATE the enrollment. This obligation is applicable even when your child is absent due to illness, vacation, holidays, inclement weather or other causes. You agree to notify the Center in writing at least one month in advance if your child will not attend due to vacation or other plans. _____ (Initial)

9. Readmission after Illness.

State licensing regulations require that, if your child has been ill, he or she may not be readmitted to the Center until he or she is free of symptoms for 24 hours without any fever reducing medications. You hereby agree to abide by this requirement and agree that the decision of the Center's Director shall govern such a readmission. _____ (Initial)

Some communicable diseases may cause the child to be absent for a longer time period in order to protect the health of the staff and children. **The center will dictate the time frame the child must stay home regardless of the doctor's timeline.** _____ (Initial)

Medication: Legacy Child Development Center does not apply any sunscreen, eye drops or bug repellent to children with or without a doctor's note. Only parent(s) may apply when such is needed. _____ (Initial)

10. Holidays and Other Closings.

The Center will be closed on the following holidays: New Year's Day, Martin Luther King, Jr.'s Birthday, Columbus Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, and the week of Christmas. If any holiday falls on a Saturday or Sunday, Legacy Child Development Center may be closed on the following Monday. Legacy Child Development Center is also closed

2-3 days per year for staff professional development. Tuition is due in full for these days. _____ (Initial)

NOTE: Legacy Child Development Center is not a religious school; therefore, Legacy Child Development Center does not single out any one religious holiday to celebrate in our classrooms in order to show respect for other religious holidays that may be celebrated by our families. _____ (Initial)

11. Inclement/Emergency Closings.

Sometimes Legacy Child Development Center must close because of emergencies or inclement weather. When you are not sure about the closing of the center, please call the office by 5:30am or check our website for updates. Legacy Child Development Center will also send out an alert by email and or text. Tuition fees are still due during emergency and/or inclement weather closings. Refunds or credits will not be given.

_____ (Initial)

12. Suspension.

In the judgment of the Center Director, or designate, if the child's behavior threatens the physical or mental health of other children or of the staff of the Center, the Center Director or designate will call the parent(s) or guardian(s) to remove the child for the rest of the day. Legacy Child Development Center requires that the child be picked-up within the hour of being notified. Parent or guardian shall continue to be responsible for the daily tuition for that day. _____ (Initial)

13. Withdrawal by Parent.

You must give the Center Director at least one month's notice in writing if you wish to withdraw your child from the Center. If you give such notice and if an enrollment deposit was received during enrollment, you may use your Deposit as a credit against your last month's tuition. If you do not give such notice, and a deposit was not received at enrollment, you will still be responsible for your entire last 30-days tuition plus any previously unpaid balances. If you do not give such notice, your entire Enrollment Deposit and any prepaid tuition will be forfeited. _____ (Initial)

14. Termination by Center.

a. The Center may terminate your child's enrollment in the Center, effective immediately, if any of the following conditions arise:

- (1) In the judgment of the Center Director, the child's behavior or the parent's behavior in the Center threatens the physical or mental health of other children or of the staff or other parents of the Center;
- (2) Tuition is not paid on or before the fifth calendar day of the month if tuition is paid monthly, or by Wednesday at noon if tuition is paid weekly;
- (3) The child is routinely picked up later than the Center closing time or more than thirty (30) minutes late two (2) or more times in a one-month period.
- (4) The child is ill when brought to the Center more than three (3) times within any thirty (30)-day period, or the parent fails to pick up a sick child within one hour after being notified of the sickness more than two (2) times during any six (6)-month period.

If enrollment is terminated because of any of the above conditions, the Enrollment Deposit will not be refunded and may not be used as a credit against unpaid tuition, and any prepaid tuition will be forfeited.

b. Two Weeks' Notice. The Center may terminate your child's enrollment upon two (2)-weeks' notice to you if any of the following conditions arise:

- (1) Any of the conditions listed in (a) above has occurred, and the Center has not exercised its right to terminate enrollment immediately;
- (2) In the judgment of the Center Director, the Center's program does not meet the developmental or special needs of your child
- (3) You fail to abide by the terms of this Agreement _____ (Initial)

If your enrollment is terminated under this section (b) for reasons other than non-payment of tuition, you will be allowed to use your Enrollment Deposit as a credit toward your tuition. If your enrollment is terminated for non-payment of tuition, your entire Enrollment Deposit and any prepaid tuition will be forfeited.

15. Child Custody/Separation/Divorce/Other Personal Issues.

Issues relating to child custody, separation and/or divorce or other personal issues are between the parties involved and should not involve the School or its personnel. The School does not enforce custody agreements, nor does it facilitate supervised visitation. Teachers and administrators need to be focused on the children at the School rather than the outside personal issues of the families. If the Administration judges that a family's personal situation becomes or threatens to become a problem, this is grounds for immediate termination of enrollment.

While we sympathize with families wrestling with these types of issues, the School needs clear "all or nothing" directions regarding who is allowed to pick up children. For example, "only mom is allowed to pick up" or "only dad or dad's mother are allowed to pick up" or "both parents are allowed to pick up." If there is a custody arrangement regarding different parents picking up on certain days, and the wrong parent picks up, this is an issue to be taken up with a lawyer or the Court, not with the School. _____ (Initial)

16. Additional Reminders.

No Cell Phone Zone for All

Legacy Child Development Center has a **no cell phone zone** from your car into the building! Parents, please refrain from using your cell phone at Legacy Child Development Center during pick up and drop off. Teachers have very limited times to communicate with you, so please be available to chat with them about your child's day during drop-off and/or pick-up. _____ (Initial)

No-Fraternizing Policy

Staff members are not allowed to create personal relationships with parents outside of Legacy Child Development Center's business hours. If a staff member does decide to fraternize with any parent that is currently enrolled at Legacy Child Development Center, that staff member and the parent's enrollment may be terminated at the discretion of the owner. _____ (Initial)

NO Hair Beads Policy

Due to the number of beads that are found on the floor and in children's mouths and even noses, we have been forced to implement a NO HAIR BEADS policy for the daycare center. Please do not put beads in your child's hair. If they come to school with beads in their hair we will remove them. They pose a serious danger to all children in the center. _____ (Initial)

(Before/After-Care Students are Exempt from this policy).

10-Hour Rule

Children maximum number of hours at Legacy Child Development Center is 10 hours. I understand that I will be charged an additional \$25.00 per week if my child stays over the contractual agreement, or I will be charged a late fee of \$25 as outlined in this agreement. _____ (Initial)

Safety and Security

For safety and security reasons, **please do not hold the front door open for anyone.** Every parent must use his or her code to enter the building. If the person does not have a code, please instruct the person to ring the doorbell and show their ID or contact a staff member to do so. _____ (Initial)

Parking

Please do not park or stand in the fire lane or around the circle. All cars must be parked in a parking space in order to allow buses and parents to exit the parking lot without being help up. _____ (Initial)

No Admittance after 9:00 a.m. / Shots

Children will not be admitted after 9:00 a.m. without a doctor’s note. If a child was administered shots during the doctor’s visit, the child may not return to school due to potential complications from the shots and/or fever symptoms associated with the medicine that often makes the child irritable. ____ (Initial)

No child will be admitted during nap time between 1 p.m.-3 p.m. We highly recommend that parents schedule doctors’ appointments during the early morning hours in order to get back to the center prior to nap time.

NOTE: Siblings under the age of 18 are not allowed in the classrooms.____ (Initial)

17.Field Trip Participation.

You acknowledge and agree that the Center’s regular program includes field trips and other off-premises activities that involve transporting the children on public transportation, in chartered vehicles, or in vehicles that are driven by Legacy Child Development Center staff and parent volunteers. You will be asked to sign a separate Field Trip Permission Form for each excursion. **You acknowledge and agree that no alternate care may be available at the Center in case you do not wish your child to attend such field trip or field trips, and that no tuition refund will be given in such case.**

Each parent **must** participate in and attend at least 1 field trip per year with their child(ren). ____ (Initial)

If the Center Director or Senior Staff determines that the child needs individual attention, the parent(s) may be requested to attend the field trip with the child, or the child may not be allowed to participate. No alternate care will be provided for any child that will not attend the trip (this only pertains to three- and four-year-old children). If a child is not potty-trained, that child must be accompanied on field trips by a parent or guardian.

Infants-to-Two’s are not expected to attend without a parent due to their age.

18.Publicity and Outside Consultants.

We ask for your permission for your child to be photographed or captured via digital imagery, videotaped, for publicity, news purposes, Website Page, Social Media and for marketing and educational purposes?

____Yes ____No (Initial)

19.Liability Release.

Legacy Child Development Center maintains an insurance policy to cover its liability for injuries, losses, and damage that may occur to your child, your child’s property, or your property caused by fire, theft, storm, or other causes. Acting on behalf of yourself and your child, you hereby waive and agree to release any claims that you, your child, or your child’s heirs and successors may have against Legacy Child Development Center, or any successor corporation, or against any officer, shareholder, employee, or agent of Legacy Child Development Center, or any successor corporation, for any and all injuries, losses, and damage to your child, your child’s personal property, and your personal property to the extent that those injuries, losses, and damage are not covered by the insurance policy maintained by Legacy Child Development Center, or any successor corporation, or to the extent that the monetary amount of such injuries, losses, or damage exceed any amount payable under such insurance policies. You agree to be responsible for and hold harmless Legacy Child Development Center, any successor corporation, and any of the officers, shareholders, or directors of Legacy Child Development Center, or any successor corporation from and against any and all claims, suits, judgments, or costs that may be brought against Legacy Child Development Center, any successor corporation, its officers, employees, shareholders, or agents of Legacy Child Development Center, for the actual or alleged acts or omissions of you or your child(ren).

20.Certification That All Information Is Correct.

The following attachments form a part of this Enrollment Agreement. You hereby certify that you have accurately completed all the forms listed below, and that you have read and agree to abide by all provisions of the Parent Handbook. You agree to notify Legacy Child Development Center if there is any change in the

information you have supplied on the forms listed below:

- a. Deposit Acknowledgment/Receipt
- b. Developmental History Form
- c. Pick-Up Release Form
- d. Custody Information Form (if applicable)
- e. Emergency Information Cards (2)
- f. Authorization to Treat a Minor Form (notarized)
- g. Child Health Inventory and Immunization Record.
- h. Receipt of Parent Manual
- i. Government-Issued ID
- j. Tuition Express
- k. Form K. Meal Plan
- l. Application

21. Severability/Unenforced Terms Not Waived.

If any term of this Agreement is declared invalid or unenforceable, it will be severed and all other terms will remain effective, and they will be construed as though the invalid or unenforceable term did not exist. If Legacy Child Development Center, elects not to require that you comply with any term of this Agreement, Legacy Child Development Center will not be deemed to have waived its right to demand compliance with said term at a later time.

AGREED TO

Parent's or Guardian's Signature _____ Date _____

Parent's or Guardian's Signature _____ Date _____

Center Director/Assistant Signature _____ Date _____

Legacy Child Development Center

ACKNOWLEDGMENT OF ENROLLMENT DEPOSIT

The non-refundable deposit guarantees you space for your child (or children) in the appropriate classroom(s) when space becomes available. Enrollment space is reserved and secured with a deposit for up-to 2-months to the desired start date of enrollment.

Your deposit will be held for one day (24 hours) in order to allow parents to read through and understand the Enrollment Agreement. A signed Agreement returned within 24 hours ensures the child's place and commits the parent(s) to all policies and procedures. If the agreement is returned unsigned within 24 hours, it is assumed that the child is not enrolled. No space will be held, and the deposit check will be returned.

If an Agreement is not returned within 24 hours, signed or unsigned, the space is forfeited, and the deposit is forfeited. _____ (Initial)

If a space is available immediately in the appropriate classroom, the parent(s) may fulfill all of the requirements as soon as possible, the same day if necessary, and the child may be enrolled in the class. A space is not held without a deposit. Your deposit is credited to your first two weeks of tuition.

Be advised, that tuition rates are subject to change AT ANY TIME during the space-withholding period.

The deposit required to reserve a space is \$_____. The child will be enrolled in the _____ Classroom.

A deposit in the amount of \$_____ has been received from _____ to reserve a space for _____. (Child's Name)

Deposit received on _____ (DATE) at _____ (TIME) (am/pm).

This deposit will be held for 24 hours from the time noted above. A signed Agreement must be returned within 24 hours to ensure your child's space. Failure to return an unsigned Agreement within 24 hours will result in a forfeiture of the deposit in full.

I understand and agree to the above.

Parent's Signature _____ Date/Time _____

Parent's Signature _____ Date/Time _____

Center Director's/Assistant Director's Signature _____

Late Fee Pick-Up Policy

Dear Parents:

To avoid a large number of children remaining at Legacy Child Development Center after closing, the following policy has been implemented at Legacy Child Development Center:

Legacy Child Development Center closes at 5:30 pm. It is suggested that children be picked up by 5:00 pm. Children not picked up by 5:15 pm will be brought into the front office to wait for their parents and the late pick-up fee will begin to be assessed.

Your child anticipates your arrival and becomes worried and anxious if his/her classmates have all been picked-up while his/her parents have yet to appear. Additionally, our staff members put in an entire full day at Legacy Child Development Center; and understandably they are ready to return to their families and carry out their personal plans for the evening. It is unreasonable to impose such inconvenience upon them.

Out of respect to our staff and their time, please make arrangements to pick-up your child before the close of business. Be advised that if you arrive after 6:15 pm, you will be presented with a late fee form, assessed for the total amount of time for your late arrival.

With no exception, LATE FEES ARE PAYABLE AT PICK-UP.

Late fees are payable in cash, personal checks, or credit cards (with the appropriate processing fee). You will be asked to sign a Late Fee Pick-up Form upon your arrival.

Late Fee Per Child: \$15.00 for up to the first 5 minutes
 \$1.00 for each additional minute

Fees are payable directly to the office staff.

If a family has an emergency near the end of the day, such as a car breaking down an illness, or traffic jams, parents must first inform the Center, and then make alternate plans for pick-up. The late fee will be imposed even under emergency conditions.

After six incidents of late pick-ups, your child will not be able to attend the Center for the next day. Additionally, your late pick-up record will be reviewed in consideration for future enrollment with Legacy Child Development Center.

Refusal to pay assessed late fees or confrontational behavior towards our staff concerning the late fee assessments is strictly prohibited and will jeopardize your child's enrollment at Legacy Child Development Center.

CAFCP 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:	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 _____

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

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

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

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

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

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

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>
Last			First		Middle
Address: _____					
Number		Street		Apt#	City
State			Zip		
Parent/Guardian Name(s)		Relationship		Phone Number(s)	
		W: _____		C: _____	
		W: _____		C: _____	
Medical Care Provider Name: _____ Address: _____ Phone: _____		Health Care Specialist Name: _____ Address: _____ Phone: _____		Dental Care Provider Name: _____ Address: _____ Phone: _____	
				Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Child Care Scholarship <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Last Time Child Seen for Physical Exam: Dental Care Specialist:	
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	<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? <input type="checkbox"/> No <input type="checkbox"/> 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.) <input type="checkbox"/> No <input type="checkbox"/> 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.) <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					Date _____

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

Child's Name:			Birth Date:			Sex	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child receive care from a Health Care Specialist/Consultant? <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
8. Are there any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
9. RECORD OF IMMUNIZATIONS – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.)							
10. RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620) Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.							

Additional Comments: _____

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

MARYLAND DEPARTMENT OF HEALTH 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
	Select a test type.		
	Select a test type.		
	Select a test type.		

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. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> Name Title </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> Signature Date </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Clinic/Office Name, Address, Phone</div> <div style="border: 1px solid black; height: 100px;"></div>
2. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> Name Title </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> Signature Date </div>	

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

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 ($\mu\text{g}/\text{dL}$). 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 $\geq 3.5 \mu\text{g}/\text{dL}$, 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>

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

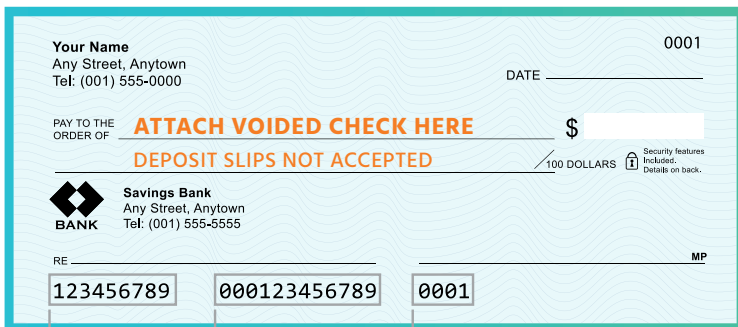
COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date		
Cardholder Signature	Date		

SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

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**Child Care Centers
Meal Benefit Application
July 1, 2024 - June 30, 2025**

Complete one application per household. For more information, read **Instructions for Completing** or call [phone number]

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 Do any Household Members (including you) currently participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)? Circle One: Yes No

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number:

Step 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:

Check if No SSN:

Step 4 Contact Information and Adult Signature

I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

Hispanic or Latino
 Not Hispanic or Latino

Race (Check one or more):

American Indian or Alaskan Native
 Asian

Black or African American
 Native Hawaiian or Other Pacific Islander

White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): \$ _____

Weekly Every 2 Weeks Twice a Month Monthly Yearly

Eligibility: Free Categorically Eligible Reduced Paid

Determining Official's Signature: _____

Date: _____

Date Withdrawn: _____

**Maryland State Department of Education
Office of School and Community Nutrition Programs
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM**

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home

1. Child's Name		Child's Date of Birth (MM/DD/YYYY)	
<p>Times Child Normally in Care (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;">Hours from: _____ to _____</p>	<p>Check (✓) the days your child normally attends:</p> <p><input type="checkbox"/> Monday <input type="checkbox"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday</p>	<p>Check (✓) the meals that your child will receive while in care:</p> <p><input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack</p>	

2. Child's Name		Child's Date of Birth (MM/DD/YYYY)	
<p>Times Child Normally in Care (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;">Hours from: _____ to _____</p>	<p>Check (✓) the days your child normally attends:</p> <p><input type="checkbox"/> Monday <input type="checkbox"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday</p>	<p>Check (✓) the meals that your child will receive while in care:</p> <p><input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack</p>	

3. Child's Name		Child's Date of Birth (MM/DD/YYYY)	
<p>Times Child Normally in Care (For example 7:30 AM – 5 PM)</p> <p style="text-align: center;">Hours from: _____ to _____</p>	<p>Check (✓) the days your child normally attends:</p> <p><input type="checkbox"/> Monday <input type="checkbox"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday</p>	<p>Check (✓) the meals that your child will receive while in care:</p> <p><input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack</p>	

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____