Berlin Education Station

PRE-REGISTRATION PACKET

10008 Old Ocean City Blvd
Berlin MD 21811
(410)629-1630
BerlinActivitiesDepot@gmail.com

This page is intentionally left blank for tour notes:

Welcome to Berlin Education Station!

Below is a list of paperwork that is required by the Childcare Administration and Berlin Education Station. All paperwork needs to be completed prior to admission into the program. Some paperwork may need to be completed by a doctor and are noted so below.

_____ _____

(Parent Signature) *(Date)*

Item	Instructions
Health Inventory Part (1)	Complete top section & answer all medical questions
Health Inventory Part (2)	Must be completed by your Physician with updated shot records. As children get shots please provide the center with updated records.
Health Inventory Part Addendum	Top completed by Physician, middle completed by parent
Health Inventory Part (4)	Completed by Physician & parent
Food Program Subsidy Form	In order to qualify for meals, we need this completed and signed by a parent/guardian. Required for *all* students
Parent Contract/Enrollment Agreement	Please read carefully and sign
Parents Guide to Regulated Childcare	Read page (7) carefully and sign on page (8)
Meal/Picture/Party Permission slips/Hanbook receipt acknowledgment	Sign highlighted area
Emergency Card	Complete as to who to contact in case of emergency and who is able to pick up your child. Sign bottom

Additional Paperwork:

Tigers and under:

- Lead Form
- New child in-take form
- Formula waiver

Lizards and up:

- Lead Form
- New child in-take form
- Transportation waiver

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. 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 (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children 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. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. 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://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their 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 provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

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 during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

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.

_____ _____
Signature of Parent/Guardian Date

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

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

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 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: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature:_____ Date: _____

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
LeadTest Indicated: DHMH 4620 ☐ Yes ☐ No	**Test #1**	**Test#2**	**Test # 1**	**Test #2**

_____has had a complete physical examination and any concerns have been noted above.
(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

CHILD'S NAME_____/_____/_____
LAST FIRST MIDDLE

CHILD'S ADDRESS_____/_____/_____/_____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE____/____/____ PHONE_____

PARENT OR GUARDIAN_____/_____/_____
LAST FIRST MIDDLE

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

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

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

Parent or Guardian Name (Print):_____ **Signature**: _____ **Date**: _____

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

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

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

Comments:

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

Provider Name:_____ Signature:_____

Date:_____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

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

Parent or Guardian Name (Print):_____Signature:_____Date: _____

****

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

Provider Name:_____ Signature:_____

Date:_____ Phone: _____

Office Address: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

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

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

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

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

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

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

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

Prince George's
20703
20710
20712
20722
20731

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

Queen Anne's
21607
21617
21620
21623
21628

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

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

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

EMERGENCY FORM

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

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

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

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

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

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

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

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ____

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

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

(3) To prevent incidents: ______________________________

____

- -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________________

____

____

____

COMMENTS: ____

____

____

____

____

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

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

______________________________ ______________________________
Name of Health Practitioner Date

______________________________ (_____)______________________________
Signature of Health Practitioner Telephone Number

Berlin Education Station

Dear Participant:

Berlin Education Station offers healthy meals every day. Although all participants receive meals at no charge, the U.S. Department of Agriculture (USDA) provides funds that support the nutrition program based on your eligibility. This letter is a request for you to complete the information on the enclosed Meal Benefit Application to assist our agency's food service program.

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH ENROLLED PARTICIPANT? No. Use one Meal Benefit Application for all participants in your household. We cannon approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: Berlin Education Station.
2. ADDITIONAL USDA REIMBURSEMENT IS AVAILABLE TO OUR AGENCY FOR MEALS SERVCED TO PARTICIPANTS IN THE FOLLOWING HOUSEHOLDS:
    - Households receiving benefits from the Food Supplement Program (FSP) or Temorary Cash Assistance (TCA).
    - Recipients of Medicaid or SSI.
    - Households with gross income within the free limites on the Federal Income Eligibility Guidelines.
    - Some households participating in WIC.
3. I COMPLETED AN APPLICATION LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your applicationis only good for one year. You must send in a new application each year.
4. WILL THE INFORMATION I GIVE BE CHECKED. Yes, and we may also ask you to send written proof.
5. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your household members do not have to be a U.S. citizen to qualify.
6. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? Your household includes the participant, and if residing with the participant, the spouse, and dependent children of the participant.
7. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
8. WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY? Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.
9. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for FSP, TCA, and medical assistance programs or other assistance benefits, contact your local assistance office or call 1-800-332-6347.

If you have other questions or need help, call (410)629-1630

Sincerely,
Berlin Education Station

Meal Benefit Application for Child Care Centers

July 1, 2019 - June 30, 2020

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 Food Supplement Program (FSP) 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, age, 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)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	**Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

2. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	**Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

3. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM)	**Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday ☐ Sunday
		Check (✓) the meals that your child will receive while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____

Rev. 8/19

Enrollment Agreement

Financial Commitment/Contract

Childs Name:	Date of Birth:
Classroom:	Date:

Hours of Operation

Berlin Education Station is open from 7:30 a.m. until 5:15 p.m. Monday thru Friday. Any child or parent in the building prior to or after these hours will be charged the $5.00 per minute early drop off or late pick up fee. We are closed for New Year's Eve, New Year's Day, Good Friday, Easter Monday, Memorial Day, July 4th, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve, Christmas Day and four scheduled in-service days. Berlin Education Station closes early on Halloween. Berlin Education Station hours of operation are subject to change for any reason at any time. Tuition is not reduced due to closures or student absence. In the event a holiday or family vacation is on a Monday; you are responsible for having payment in our office on or before Friday or cards on file will be auto billed.

Extended Center/Gym Hours- Berlin Education Station offers extended care from 7:00 a.m.-6:00 p.m. for $27.50 per week in addition to weekly tuition. These extended care hours must be contracted and extended care fees will be added directly to your weekly tuition. Berlin Education Station offers Extra Early/Late Care which covers 6:45 a.m.-6:00 p.m. for $55.00 per week in addition to weekly tuition. Berlin Education Station reserves the right to charge the $5.00 per minute per child early drop off or late pick up fees to anyone who has not contracted extended care but arrives before 7:30 a.m. or is still on premises after 5:15 p.m.. If you will be needing extended care for a temporary circumstance, you may sign up for extended care one week in advance with the Director.

Late pick up fees $5.00 per minute if you are in the building prior to or after our operating hours notated above. You will be charged $5.00 per minute that your child is in the center before open time (7:30 a.m.) or after close time (5:15 p.m.) unless you have signed up for extended care at least a week in advance. After 30 minutes have passed after closing time (6:00 p.m.), according to state child care licensing regulations, your child may be released to child protective services or other local authorities if you or the listed authorized persons to pick up have not picked up and cannot be reached.

Berlin Education Station will be open during regular operating hours and days whenever possible. In the event of severe weather or emergency situations, families will be notified by lifecubby alerts if/and when the center will reopen. In the event of an early closure, it is my responsibility to organize early pick up for my child.

Tuition

I understand the Weekly/monthly tuition Fees are as follows:

TUITION/WEEK	DISCOUNT TYPE	DISCOUNT	ADDITIONAL SERVICES –list	COST/WEEK TOTAL TUITION
$		$		

Financial Terms

1. All tuition is due before services are rendered.
2. My child's tuition will not be adjusted in the event of vacation, holidays, weather, days off, or illness, school closure for any reason. If I would like my child to attend additional days, I understand I must get pre-approval from the Director and agree to pay the additional day fee of $50.00- $60.00. I understand I cannot switch days of enrollment. I agree to pay the full tuition rate every week for the duration of my enrollment.
3. My child's full week tuition is due every Friday prior to 5:00 p.m. for the coming week. If my payment is not made by this time, my card on file will be charged. Returned card payments will be auto billed a $35.00 Return Fee. Children are not permitted to attend if payment is not received by Monday morning drop off. I will be charged an additional $15.00 late fee each additional day. I will continue to be charged the late fee every week until I have paid all backed tuition and late fees in full. **I understand that my child cannot return to Berlin Education Station until all back owed tuition, late fees, and any other charges are paid in full, I further understand that my child's spot will be filled with the next person on the waitlist.**
4. In the event of my child leaving the center, I agree to give a full 1 month's (30 business days) notice by 5pm on Monday. Notices received on any other day of the week will not be recorded until the following Monday. The 1 month will be calculated from the Monday recorded. If I do not give a full 1 month WRITTEN notice, I agree to pay the full tuition for the coming two weeks whether my child attends or not. **All enrollment fees and curriculum fees are nonrefundable and nontransferable. I understand that the enrollment fees and a curriculum fees do not go towards any part of my last month's tuition, and that Curriculum Fees are Annual.**
5. There is an annual curriculum fee of $50.00 due every September 1st. I agree to pay the curriculum fee and understand that curriculum fees are not refundable in the event I choose to withdraw my child. I understand if I were to re-enroll at Berlin Education Station, these fees would be due again at time of sign up.
6. Berlin Education Station reserves the right to increase tuition at any time with notice by any means of writing.
7. Additional fees I have signed up for over and above those included in my weekly tuition such as; extra gymnastics, extra soccer, extended care etc. are automatically charged to my child's account every week even if my child is not present. To change these extracurricular activities, we must receive 1 months' notice in writing.
8. If I participate in the Child Care Subsidy program, current vouchers must be on file. There is a 7.14 weekly service fee for POC processing.
9. Summer Activities fees are assessed to all students for the weeks of Memorial Day to Labor Day- these fees are $10 per week ages 2 and up.
10. In the event my card on file declines for any reason, I will be charged $35.00 per occurrence.
11. I agree to hold Berlin Education Station, Twisters Inc, director, and/or staff harmless of any accident. I agree to having read the parent handbook and will adhere to all rules as stated in the handbook. I agree that this contract will automatically update when the year has lapsed. I understand I will be responsible for paying any; and all costs associated with small claims court, including legal fees, my outstanding balance and accruing weekly interest and late fees even after notice is given.
12. I agree to keep a valid credit card on file as the primary means of weekly payment.

Parent/Guardian Signature Date Director Signature Date Owner Signature Date

For Office Use	Day	Hours of Attendance	Meals (please circle)			
	Monday		Breakfast	A.M. snack	Lunch	P.M. Snack
	Tuesday		Breakfast	A.M. snack	Lunch	P.M. Snack
	Wednesday		Breakfast	A.M. snack	Lunch	P.M. Snack
	Thursday		Breakfast	A.M. snack	Lunch	P.M. Snack
	Friday		Breakfast	A.M. snack	Lunch	P.M. Snack

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

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8770
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worchester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

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

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

Resources

Child Care Subsidy - Assists parents with cost of childcare

1-866-243-8796

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

cpsc.org

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

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

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

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Larry Hogan, Governor

Karen B. Salmon, Ph.D.
State Superintendent of Schools

OCC 1524 (8/2016)

Guide to Regulated Child Care

Important Information About Child Care Facilities

Who Regulates Child Care?

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

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

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

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

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

What are the types of Child Care Facilities?

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

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

Child Care Center – non-residential care

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

All facilities must meet the following requirements:

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

Did You Know?

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

Permission Agreements

- **Meal time Permission Slip:**
  _____ (child's name) has permission to say Grace during meal time.

  Parent Signature: _____

- **Picture Permission Slip:**
  _____ (child's name) has permission to be photographed at the centers discretion for advertisement, press release purpose, and for the yearbook.

  Parent Signature: _____

- **Party Participation:**
  _____(child's name) has permission to participate in holiday parties hosted by the learning center during regular business hours.

  Parent Signature: _____

- **Security Video Surveillance:**
  Berlin Education Station has my permission to videotape _____ (child's name) for security purposes as well as a convenience for parents of the center to view daily activities and routines.

  Parent Signature: _____

- **Handbook Receipt Acknowledgment:**
  I, _____ parent of _____ (child's name) have received a parent handbook and am aware of all rules and policies of Berlin Education Station. I will abide by the center rules at all times. I have received a copy of the Regulated Guide to Child Care in my enrollment packet.

  Parent Signature: _____

New Student In-Take Form

Child's Name: _____ **Birthday:** _____

Parent/Guardian Name: _____

SLEEPING ROUTINE

Pre-nap routines:

_____

How many naps per day: _____ **Length of nap:** _____

What times:

_____

Walking behavior/routine:

_____

Special concerns:

_____

Back to sleep is highly recommended

EATING ROUTINE

LIQUIDS:

JUICE

What kind:

_____

When:

_____

Amount: _____ **Bottle:** _____ **Cup:** _____

MILK/FORMULA

What kind:

_____

When:

_____

Amount: _____ **Bottle:** _____ **Cup:** _____

LIQUIDS CONT.:

OTHER

What kind:

_____

When:

_____

Amount: _____ **Bottle:** _____ **Cup:** _____

SOLIDS:

Type:

_____

When:

_____

Amount: _____

Does your child eat unassisted? _____ **Does he/she enjoy eating:** _____

How is child fed? Help in lap: _____ **Highchair:** _____

Other:

_____

Parent suggestions for feeding:

_____

Any special feeding issues:

_____

Any known FOOD ALLERGIES:

_____

What kind of food does he/she like:

_____

What kind of food does he/she dislike:

_____

DIAPERING ROUTINE

Type of diapers used:

_____

Are plastic pants used:

_____

Is child's skin highly sensitive: _____ Frequent diaper rash: _____

Oil:_____ Powder: _____ Lotion: _____

Ointment: _____ Other: _____

IF MEDICATED PRODUCTS ARE USED, IT MUST BE ACCOMPANIED BY A MEDICATION ORDER FORM SIGNED BY THE PARENT

Describe any special diapering procedures:

_____

Are bowel movements regular: _____ How many per day: _____

Approximate times: _____

Is diarrhea a problem: _____ Constipation: _____

HEALTH & GROWTH INFORMATION

Does child have a 'fussy' time: _____ When: _____

How is this handled:

_____

Does child sit up by him/herself:_____ Crawl: _____

Pull up: _____ Stand: _____ Walk: _____

Any known allergies other than food related:

_____

Does he/she take any medication on regular basis:

_____

ACTIVITY ROUTINE

At home, my child can do the following activities:

_____

I would like my child to learn to do the following activities:

_____

Are there any special considerations that the staff need to know about your child:

_____

THIS CENTER ENSURES THAT DAILY EVERY CHILD IS:
HELD, PLAYED WITH AND TALKED TO; EXCEPT WHEN SLEEPING.
GIVEN OPPORTUNITIES TO SIT, CRAWL, TODDLE OR WALK OUTSIDE THE INFANT'S CRIB; EXCEPT IN INCLEMENT WEATHER, TAKEN OUTDOORS.

Enrollment date: _____

_____	_____
(Parent/Guardian Signature)	*(Date)*
_____	_____
(Leah Teacher Signature)	*(Date)*
_____	_____
(Assistant Teacher Signature)	*(Date)*

Start Date: _____
Birth Date: _____

Child's Name: _____
First Middle Last

Does your child have a nickname he/she would prefer to use? _____
Sibling's names and ages: _____
_____
Please list other members of the household: _____
_____
Are there other adults that care for your child? _____
_____

Please help us get to know your child by completing the following information. All information is kept confidential and shared only with the classroom teachers.

Health History: Does your child have:

Any known allergies (food, environmental, medication)? _____
_____
Any medications taken regularly? _____
_____
Have any physical disabilities? _____
_____
Have there been any serious illnesses or hospitalizations? _____
_____
Receive assistance from Child Find or received assistance in the past from Birth to Three? _____
_____
If so, does your child have an IEP? _____
Please note if your child does have an IEP, that information must be shared with the classroom teacher so that we can work together to help your child succeed.

Family:

What language(s) are spoken at home? _____
What language(s) does your child speak? _____
What holidays are celebrated in the home? _____
_____
What are some of your child's favorite activities? _____
_____
How does your child handle anger and frustration? _____
What steps do you take when your child is angry/frustrated/not listening? _____
Does your child wander away or hide while in public places? _____
Does your child indicate when he/she needs to use the bathroom? _____
Does your child have frequent toilet accidents? _____
Does your child wipe himself/herself after a bowel movement? _____
Does your child need assistance with clothing when using the bathroom? _____
Is your child able to dress self (put on and remove basic clothing and outerwear)? _____
Does your child nap? (Please circle) Daily 2-3x week Rarely
What is your child's night sleep schedule? _____
_____

Personal/Social Relationships:

Has your child had any previous school or play experience? _____ If yes, where and for how long? _____

_____

Was this a good experience for your child? _____

_____

Generally, how does your child adjust to new experiences? _____

_____

Who does your child seem to enjoy spending time with when given a choice, children or adults? _____

What would you like your child to gain from this experience? _____

_____

What do you feel are your child's assets/qualities? _____

_____

In what areas of your child's development do you feel he/she needs encouragement? _____

_____

Is there any further information you would like to share about your child? _____

_____

_____

Families are encouraged to become involved in Center activities. Please check any areas in which you would like to enrich the lives of the children in your child's program. This is strictly volunteer and would be according to your schedule. We really appreciate any help you can give us!

_____ Volunteering to read a story or help with an art project
_____ Giving time as a family to work in the garden area
_____ Helping with fundraising
_____ Sharing a special talent
_____ Sharing information about your job
_____ Copying surveys/manuals/information etc.
_____ Making dinner for staff for their monthly night staff meetings
_____ Doing a cooking project in the classroom
_____ Being a classroom representative
_____ Joining the Board of Directors
_____ Anywhere needed
_____ Other Suggestions

To help us determine other ways that you could be involved, please answer the following:
Parent's/Guardian's Job Title(s)

_____

_____

Parent or Guardian (Please Print) **Date**

UPDATED ARE REQUIRED AT LEAST EVERY THREE MONTHS AND INITIALS OF THE PARENT(S) ARE NECESSARY

UPDATES:

_____

(Parent/Guardian Signature) *(Date)*

CHANGES:

_____

_____

_____

UPDATES:

_____

(Parent/Guardian Signature) *(Date)*

CHANGES:

_____

_____

_____

UPDATES:

_____

(Parent/Guardian Signature) *(Date)*

CHANGES:

_____

_____

_____

UPDATES:

_____

(Parent/Guardian Signature) *(Date)*

CHANGES:

_____

_____

_____

Credit Card Authorization Form

I authorize Twisters Inc. to charge my credit card in the amount of _____ weekly/monthly.

This payment is for _____ *(child)* enrolled in _____ *(program).* I also understand that my credit card information will be stored on file at Twisters Inc. for future payments that I may need to make. I understand if my weekly tuition is not paid by 5:00PM Monday, this card will automatically be charged for my weekly tuition.

_____ I understand if payment is charged to this card and it declines for any reason, there is a $35.00 decline fee that will be charged in addition to my tuition.

_____

(Parent/Guardian Signature) *(Date)*

Card Type: □ Visa □ Mastercard □ Discover □ American Express

Card Number:

_____

Expiration Date: _____ Security Code: _____

_____

(Cardholder's Signature) *(Date)*

Welcome to Berlin Education Station

Steps for Re-Acceptance into our Program after Covid-19

Now that you have decided to enroll your child please complete the following:

- Meet with the Director to discuss number of days, weekly tuition amount & open classes
- Complete the bottom portion of this form and attach a check for one week tuition as a non-refundable enrollment fee, $50 non-refundable annual curriculum/enrollment due every September 1st and upon first enrollment.
- Once enrollment and curriculum fees and forms are received, your child will be placed on the waiting list (if necessary spot is unavailable)
- When spot is available the Director will give required forms that need to be completed by parent.
- NEW: You will be invited to register your child into the Jack Rabbit Class system where you can make automatic payments, review your account and enrollments. The $50 curriculum fee will be automatically charged through the Jack Rabbit account Sept. 1st.
- Once forms are completed and returned your child may begin.

Child's Name: _____DOB: _____

Days Requested	Full Time (Mon-Friday) ☐	Part Time (Monday/Wednesday/Friday) ☐	Part Time (Tuesday/Thursday) ☐

Parent's Names: _____ Address: _____
Phone Number: _____
Desired Child's Start Date: _____ Available Start Date ***(for center use only):*** _____
Email: _____

I am aware that enrollment and curriculum fees are not refundable due to cancellation.
Signature: _____4 digit code assignment: ___ ___ ___ ___

My child has the following disability/IEP that Berlin Education Staff should be aware of to best take care of my child:
Please describe: _____

Desired enrollment program:

Enrollment Program/Fees	**Amount Due**
Annual curriculum/enrollment fee	$50.00 Due September 1st
Non-Refundable Enrollment fee	Equal to 1 week's tuition (any break in enrollment will result in this fee when re-registering)
Select a program from the choices below. Program: _____ Rate: _____	
Additional Services (Extended Care, Extra Early/Late Care). Service _____ Rate: _____	
Infant & Toddler Full Day Program: **(Caterpillars, Bees, Turtles & Toucans)**	**Full Time $269.50 (Monday-Friday)** **Part Time $203.50 (Monday/Wednesday/Friday)** **Part Time $170.50 (Tuesday/Thursday)**
Two Year-Old Full Day Program: **(Tigers)**	**Full Time $218.90 (Monday-Friday)** **Part Time $185.90 (Monday/Wednesday/Friday)** **Part Time $148.50 (Tuesday/Thursday)**
Three Year-Old & Four Year-Old Full Day Program: **(Lizards, Fireflies, Monkeys)**	**Full Time $207.90 (Monday-Friday)** **Part Time $174.90 (Monday/Wednesday/Friday)** **Part Time $120.90 (Tuesday/Thursday)**
Extended Care	7:00-6:00 p.m.= additional $27.50/week 2 days- $11/week 3 days- $16.50/week
Extra Early/Late Care	6:45-6:00 p.m. = additional $55.00/week 2 days- $22/week 3 days- $33/week
Enrollment Options: Must Select one that applies. Enrollment fees must be given via credit card over the phone in order to secure a spot. You will be called to see if you would like to reserve the spot. Please be sure to pay the enrollment fee at that time. Enroll in program starting June 8th ☐ Enroll in program starting Day After Labor Day ☐ Enroll in program starting January 1st 2021☐	
Total Weekly Tuition: _____	

Berlin Activities Depot Important Updates

THE EPCC PROGRAM WILL NO LONGER BE PAYING TUITION -EFFECTIVE JUNE 7TH.

Our capacity is NOT being increased. We will begin enrolling families at the rates listed below. To secure one of the spots after EPCC funding ends, you will need to pay the enrollment fee equal to 1 week's tuition as shown here.

Infant/Toddler
$269.50 Monday-Friday
$203.50 Monday, Wednesday, Friday
$170.50 Tuesday, Thursday

2 Year Old Program
$218.90 Monday-Friday
$185.90 Monday, Wednesday, Friday
$148.50 Tuesday, Thursday

3-4 Year Old Program
$207.90 Monday-Friday
$174.90 7:30-5:15 Monday, Wednesday, Friday
$120.90 Tuesday, Thursday

Hours of Care:
Rates are for 7:30-5:15

Extended Care:
7:00 am-6:00 pm=
additional $27.50/week
2 days= $11/week
3 days= $16.50/week
Extra Early/Late Care:
6:45 am-6:00 pm=
additional $55.00/week
2 days=$22/week
3 days=$33/week
Part time days are MWF or T/Th. If you need different days, you will need to enroll in a full time spot.

Child Care Subsidy will be accepted. See us for help with applying!
POC admin fee will be $10.00.

Spots will be given to families that were enrolled prior to EPCC and have continued paying tuition. Due to limited capacity, we will not be able to accept everyone back so please secure your spots ASAP. All updated paperwork must be submitted before a spot will be secured (including immunizations, lead test, updated contracts, etc.)

WWW.BERLINACTIVITESDEPOT.COM

THINKXYZADRODESIGN