BERLIN ACTIVITIES DEPOT

BEFORE & AFTER SCHOOL PROGRAM

5-15

LEARN

PLAY

ENGAGE

The program includes:

- Transportation to/from local schools
- Includes Healthy Snack
- Gymnastics Classes
- Ninja Nation Classes
- Karate Classes
- And MORE...

$85 PER WEEK

HURRY!

SPACE IS LIMITTED

Enroll Today!

(410)629-0878

10008 OLD OCEAN CITY BLVD
BERLIN MD 21811
www.berlinactivitiesdepot.com

Before Care Program

7:00AM – 8:30AM
Monday – Friday
Daily Only: $20
Before Care Only: $65/week OR $280/month

School-Aged Before & After Care Program

Monday – Friday
3:00PM – 5:15PM
2 Days per Week = $55/week OR $235/month
3 Days per Week = $65/week OR $275/month
4 Days per Week = $72/week OR $305/month
5 Days per Week = $85/week OR $340/month
Includes: Classes, Transportation & Snack

Pre-K Before & After Care Program

Please Circle: AM OR PM Transportation
Monday—Friday
5 Days per Week= $139/week
4 Days per Week= $115/week
3 Days per Week= $95/week
2 Days per Week= $85/week

Extended Care
6:45-7:00AM=$5.00/day
5:15-6:15PM=$15 Per week

After School Programs DO NOT INCLUDE: Extended Care, Delays, Early Dismissals, Days off School, Holiday Camps, Summer Camps, Annual Enrollment Fees, Extended Care Costs, OR Open Gym.

Year Round Program

Monday—Friday
3:00PM-5:15PM
5 Days per Week= $105/week
Includes: Classes, Transportation & Snack

- **Your child will be contracted into 52 weeks per year**
- **Full 52-week contract includes Before & After School Program until 5:15PM and Summer Camp with scheduled field trips per week**

Extended Care
6:45-7:00AM=$5.00/day
5:15-6:15PM=$15 Per week

After School Programs DO NOT INCLUDE: Extended Care, Delays, Early Dismissals, Days off School, Holiday Camps, Summer Camps, Annual Enrollment Fees, Extended Care Costs, OR Open Gym.

Schools We Transport To/From:

- **Showell Elementary School**
- **Ocean City Elementary School**
- **Buckingham Elementary School**
- **Berlin Intermediate School**
- **Stephen Decatur Middle & High School**

Other local schools can be included with at least 3+ enrollments

Additional Fees that are not included in Weekly Tuition:

1 Hour School Delay=$10/day

2 Hour School Delay=$14/day

Early Dismissal:

Until 5:15PM=$25/day

Until 6:15PM=$35/day

Day off School:

7:45AM-5:15PM=$35/day

9:00AM-4:00PM=$25/day

Extended Care during Days off School:

7:00AM-7:45AM=$10/day

5:15PM-6:00PM=$10/day

Transportation Attendance Policy:

A parent/guardian must notify B.A.D before 2PM if your child will not be attending our program for any reason. This is so we will know if transportation is needed on that day. A $25.00 fee will be assessed for failure to adhere to this policy and will strictly enforced.

Daily Before & After School Drop-In Rates:

Member Rate:

7:30AM-5:15PM=$35/day

5:15-6PM=$10/day

Non-Member Rate:

7:30AM-5:15PM=$40/day

5:15-6PM=$10/day

Based on Open Availability

Welcome to Berlin Activities Depot!

Need to know:

- All payments are required by Monday at 5:00 P.M. If tuition is unpaid by Monday at 5PM, your credit card on file will be charged for your tuition. If for any reason your credit card charge does not complete, a $35.00 decline fee will be automatically assessed. Failure to pay tuition will affect your child's ability to participate in B.A.D Before and After School programs.
- There will be **NO** refunds for any payments regardless of attendance for any reason.
- If transportation to and from B.A.D and your child's school is provided please ensure that your child understands proper safety and rules on the B.A.D vans.
- If your child does not have a snack or drink, they can be purchased at the "Above the Bar Grub Hub". B.A.D is not liable for any lost or stolen money that is in the child's possession. If a snack is packed please be sure it is something that will keep throughout the day. Breakfast and PM snack will be provided for your child, with a mandatory completed CACPF Form.
- Children must have money to purchase snacks, have a credit card on file or have a pre-loaded Gift Card to purchase a snack/drink at the snack bar. Snacks may never be purchased without funds.
- If your child does not have school, or a half day of school and will or will not need care from B.A.D please let us know 24 hours before the day.
- As children are coming to and from school they have their backpacks, jackets, other clothing etc; B.A.D is not liable for any lost or stolen items. Cubbies are available for your child to place their belongings. Please be sure to label everything with your child's name to ensure nothing is mixed up with another child's.
- If you have not picked up your child by the designated time that their program ends they will be placed in the aftercare extended hours class and your account will be auto billed $15.00.
- Accidents happen! B.A.D employees ensure that caution is always taken in the gym and safety comes first but accidents can still occur. If a child is hurt the correct measures are taken to take care of the situation is a safe and quick manner. After taking care of the situation the parent is immediately notified. B.A.D is not liable for any accident or injury that occurs.
- Please have your child dress appropriately for the program they attend that day.
- Students must be signed in and out using our POS system at the front desk with your designated pick up code.
- B.A.D **does not** follow Worcester County Schools inclement weather and emergency closing policies. If schools require closings, we will be closed at our own discretion. If schools are closed early due to weather or emergency B.A.D will still pick-up your child and they may be in our program until 5:15PM or extended care until 6:15PM. If earlier pick up is required for safety purposes we will inform you. There will be a $25 Early Dismissal fee charged. We make a decision to close on a case by case basis as the safety of our staff and students are our primary concern.

Parent's Responsibility Checklist:

_____1. Notify Teachers that your child will be joining Berlin Activities Depot After School Program. If transportation changes occur including a different pick up person at B.A.D or if someone else will be picking up your child from school, please notify B.A.D.

_____2. Notify the School office that your child is to be in the line for "Berlin Activities Depot".

____3. When leaving be sure your child has all of his/her belongings. Berlin Activities Depot is not responsible for any lost or stolen items.

____4. A nutritious snack and drinks will be provided. Water fountains will be located in each activity area. We have a full-service snack bar (Above the Bar Grub Hub) I understand my child can ***ONLY*** charge for additional snacks or activities if permission is granted to card on file, my child has a pre-loaded Gift Card or Cash.

We try to accommodate the needs of every individual to the best of our ability but we have guidelines to run our programs successfully. Please help us to better serve all of our members and customers by following our guidelines set forth

Sign up for Remind 101 Text Reminders:

Berlin Activities Depot Before & After School Program: Text "@BADAS19" to 81010

Berlin Activities Depot After School Policies and Procedures

In order for the After School Program to run as smoothly and safely as possible, the following policy and procedures will be mandatory:

Absences

A parent/guardian must notify B.A.D before 2:00 P.M if your child will not be attending school for any reason. This is so we will know if transportation is needed on that day. A **$25.00** fee will be assessed for failure to adhere to this policy and will be strictly enforced.

Label Property and Lost and Found

Please label all items brought to B.A.D; coats, backpacks, water bottles, etc., and check lost and found weekly. B.A.D is not liable for any lost or stolen property. All lost and found will be taken off the premises and donated weekly.

School Closings

B.A.D will be open during most Days off School; camp hours will be from 7:45AM to 5:15PM. Early drop off is available from 7AM-7:45AM, late care is also available from 5:15PM to 6:15PM at an additional $15 per week for extended Before/After care. If you need extended hours, please notify the front desk. If your child is in attendance for Early or Late extended care without notification, it will be automatically charged to the card on file.

Inclement Weather

If Worcester County Schools are closed, Berlin Activities Depot may be closed. Please listen to local radio and TV stations for closings and sign up for Remind 101. If schools close early for inclement weather or emergency, B.A.D will pick up your child from school or the bus will drop them off at B.A.D. Additional fees will apply.

Behavior Policy

Any negative behavior will not be tolerated at B.A.D. Your child will be provided with a verbal warning, a courtesy call will be given as the first offense. After that, your child will need to be picked up immediately and based on the severity of the situation may not be permitted to attend B.A.D for a designated period of time, tuition will still be due in full regardless of attendance.

Illness

Please remember, if your child is too ill to attend Public/Private school, they are too ill to attend B.A.D. If your child becomes ill at B.A.D, the parent will be immediately notified and must be picked up as soon as possible. The following guidelines will be used for all children:

Fever: If you child has a temperature of 100 degrees or higher you will be notified and the child must be picked up.

Diarrhea/Vomiting: If a child has a liquid watery stool and/or is vomiting, the parent will be notified and the child must be picked up immediately.

Medications: We do not administer any medications to your child. Please do not send your child to B.A.D if he/she has a communicable disease or does not feel well enough to participate in all activities. Please do not forget to notify Twisters is your child will be absent due to illness.

* 24 hour Return Policy for Sickness: Documentation from the child's pediatrician must be submitted to the center to note if the child is contagious or is able to return to the center. Children who have a temperature of 100.5 degrees or higher, are vomiting or have diarrhea, show symptoms of ringworm, lice, pink eye or another communicable disease will not be allowed at the center. If your child develops a symptom we will notify you, and you will be responsible for picking up your child immediately. If your child has one of the following symptoms then he/she may return the center (24) hours after all symptoms are gone and a doctor's note is provided. Also, for communicable diseases we require a doctor note stating your child has been seen and treated for the illness. Your child will not be allowed to attend until (24) hours after all symptoms are gone.

Late Pick Up Policy:

All After School Programs end at 5:15PM unless enrolled in Extended After Care Programs. If the case you are running late you may call B.A.D in advance to sign your child up for late care for a $15.00 fee until 6:15PM. If your child is here past designated enrollment time, your card on file will be automatically charged for the additional program charges. Your cooperation is greatly appreciated.

Parent Payment Obligation

I understand that my tuition is arranged to be made in weekly or monthly installments.

I fully understand that if I choose, under any circumstances, to un-enroll my child in any B.A.D program I must provide B.A.D with the required written notice for the program.

Before and After school programs require a one month notice due before the first of the month.

_____ _____

(Parent/Guardian Signature) **(Date)**

Welcome to Berlin Activities Depot

Steps for Acceptance into our Program

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

- 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
- Once forms are completed and returned your child may begin.

Please complete the following:

Child's Name: _____ DOB: _____

Program Needed (Please Circle): Before Care Only AM Pre-K PM Pre-K Before & After School

School your child is attending: _____

Parent/Guardian(s) Name: _____

Address: _____

Phone Number: _____ Child's Start Date: _____

Email: _____

I am aware that enrollment and registration fees are not refundable due to cancellation.

Parent Signature: _____

Notice to stop Auto Billing:

In order to end automatic billing of your account, please provide Berlin Activities Depot written notice one month prior to your child's last day of Before/After School care. Please note: without written notice your account will continue to be billed until notice is received and/or your Summer enrollment begins at designated fees.

Parent Signature: _____ Date:_____

Desired enrollment program:

Enrollment Program/Fees	Amount Due
Annual Curriculum 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)
Before Care Program Only	$20/day $65/week OR $280/month
School-Aged Before & After Care Program ☐ 40 weeks school year ONLY ☐ Year-Round Program 7:45AM-5:15PM	(5) $85/week OR $340/month (4) $72/week OR $305/month (3) $65/week OR $275/month (2) $55/week OR $235/month
Pre-K Before & After Care Program	(5) $139/week (4) $115/week (3) $95/week (2) $85/week
Add Extended Early Care (6:45-7:00AM)	$5/day
Add Extended Late Care (5:15-6:15PM)	$15/week
☐ 1 Hour Delay (check if your child will attend)	$10/day
☐ 2 Hour Delay (check if your child will attend)	$14/day
☐ Early Dismissal (check if your child will attend)	$25/day
☐ Day off School (check if your child will attend)	7:45AM-5:15PM $35/day 9AM-4PM $25/day
Total Weekly Amount Due:	$_____

Weekly Class Schedules:

Daily Options (based on availability)

Monday—Thursday 4:15-5:15PM

- Class Homework Help
- Outside Playground
- Gymnastics Classes
- Ninja Nation Classes
  - Karate Class
    - Tuesday 4:15-5PM
  - Jui Jitsu Class
    - Thursday 4:15-5PM

FUN Fridays

- Open Gym 3:00-5:15PM

Order of Class Preference (Number 1-4)

____ Homework Help/Zoo Crew ___Karate/Jui Jitsu ___Ninja Nation ___Gymnastics

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

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: _____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE ____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP ____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

Clinic / Office Name
Office Address/ Phone Number

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

DHMH Form 896
Rev. 2/14

Center for Immunization
www.dhmh.maryland.gov

Berlin Activities Depot must have a copy of your child's shot records, lead test and school records.

IN ORDER FOR YOUR CHILD TO BE PROVIDED WITH BREAKFAST, LUNCH AND/OR SNACK THIS FORM MUST BE COMPLETED.

19-20 CA-CCC Sample

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: _____

IN ORDER FOR YOUR CHILD TO BE PROVIDED WITH BREAKFAST, LUNCH AND/OR SNACK THIS FORM MUST BE COMPLETED.

ENROLLMENT FOR CHILD AND ADULT CARE FOOD PROGRAM

Name of Child Care Center:	

Important: This form must be updated annually.

Name(s) of Enrolled Children: (Please print)	Days in Care (Check days that apply)							Meals Served (Check meals that apply)				
	M	TU	WE	TH	FR	SA	SU	Breakfast	AM Snack	Lunch	PM Snack	Supper
1.												
2.												
3.												
4.												
5.												

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date Signed

Phone Number of Parent/Guardian: _____

Rev. 6/18

Class Registration Parameters: Class enrollments are on a first come, first serve based on payments. Classes are considered "full" with 15 registrations, once 15 registrations are received classes will be closed. Second choice classes will be honored if your first preference is full. All classes, special events, clinics and programs require at least 3 registrations to run the class or will otherwise be cancelled. As classes fill, new classes/series will be opened. Transfers to new classes may be awarded.

Order of Preference (1-4):

____ Homework Help ____ Karate/Jui Jitsu ____ Ninja Nation ____ Gymnastics

Rules and Regulations: I and my child(ren) agree to abide by the rules and regulations governing the conduct and operation of the facilities. I understand that B.A.D has the right to alter or amend any, and all, rules and regulations, including those set forth in the Membership Agreement, and we agree to abide by all such amended rules and regulations. I acknowledge that we have been provided with a copy of all current rules and regulations. I understand that our membership and the right to use B.A.D facilities and programs may be suspended or terminated at any time, with or without cause.

Additional Costs: I understand and agree that there will be special events held at B.A.D including but not limited to, meets, camps, sleep-overs, etc., and these events all incur additional fees beyond the amounts set forth in this Agreement. I also understand and agree that the cost of uniforms, equipment, supplies and food items such as snacks are not included in the cost set forth above, and must be purchased separately. Also, on scheduled days off of school, there may be additional fees for field trips at an additional cost. Arcade games and additional snacks are not included. My child can ***ONLY*** charge for additional snacks or activities if permission is granted to card on file or my child has a pre-loaded gift card.

Photograph/Video: I hereby authorize the center and its agents, successors and assigns to photograph me or my child(ren) and/or our voice without restriction and to utilize such photographs and/or voice transcriptions for any commercial purpose, including but not limited to the promotion and marketing of B.A.D and I agree that I shall not be entitled to receive any compensation whatsoever of any kind as a result of such use.

Payment: I understand that my tuition is arranged to be made in weekly installments due by Monday at 5PM or monthly installments due by the first day of each month. Notice of cancellation shall be in writing in 1 month's notice by the 1st of the month, and mailed to B.A.D by registered or certified mail. A late fee of $15.00 will be assessed for any late payments due after the originally agreed time. If the card on file declines for any reason, a $35 declined payment fee will apply to your account. Payment parameters cannot be changed.

Purchase of Care Policy: Parents must pay full price until funds are received by center. Parents are responsible for all tuition in the event that purchase of care does not pay for any reason. Parents are responsible to recertify their vouchers as needed. Lapse in state subsidy will result in parent paying the full balance. All parents' copayment is due as outlined above.

Consumer's Right to Cancellation If you move your residence more than 15 miles from the school facility, cancellation under this section requires proof of new residency and permanent address, phone number, name and address of new employer and requires **30 day advanced written notice.**

X_____Parent/Guardian Initial

Medication Administration: Any (prescribed or over the counter) medicine must have a signed physicians form from our center giving our staff permission to administer the medication. The form must be completely filled out and in line with the prescription that must be on the container. The medications first dose must be given at home. The medication and form must be turned into the front desk. Medications will not be given without these guidelines. Medications not intended to be given at the center, but in a carrying tote for the child will be turned into the front desk for the safety of all of the children in care.

Means of Communication: It is the parent's responsibility to sign up for our Remind 101 text message reminder. Collect calendars and know what the center has to offer and what is going on at the center. Berlin Activities Depot/Berlin Education Station has the right to change and modify any/all of these procedures as we see fit.

_____ I understand that I am automatically enrolled for the Summer program. If I wish to not attend B.A.D Summer program, all or part of the program, I must write my notice of intent by May 15th.

_____ I understand that Days off School/Extended Care have additional fees listed below:

7:30AM-5:30PM $35 Members $45 Non-Members

9AM-4PM $25 Members $35 Non-Members

Extended Early Care 6:45AM-7AM $5/day

Extended Late Care 5:30PM-6:15PM $15/week

1hr School Delay $10

2hr School Delay $14

____ I understand if my child is in attendance for Delays, Early Dismissals or any period of time after 8:15AM or before 3:30PM.

I understand my rights as stated above

_____ _____

(Parent/Guardian Signature) **(Date)**

Transportation Waiver

I _____, parent of, _____ give permission to Twisters INC. to transport my child to and/or from school to Twisters. This may include: early dismissal, field trips, mini day trips, emergencies, etc. I will not hold Twisters INC. DBA Berlin Activities Depot or any of its employee's liable if/when any accident, injury or death occurs.

(Parent Signature) (Date)

Days of Attendance (Please circle): Mon Tues Wed Thurs Fri

Times Needed:_____

I understand that there may be additional fees that will be added to my account including but not limited to:

-School Delays
-Early Dismissals
-Days off School
-Extended Care Early/Late

_____ _____

(Parent Signature) (Date)

My Child attends the following school:

☐ *Buckingham*
☐ *Berlin Intermediate School*
☐ *Showell Elementary*
☐ *Ocean City Elementary*
☐ *Other: _____*

Additional local school pick up may be available based on 3+ enrollments

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In the event of Inclement Weather, Bomb Threats, School Emergencies etc. at the school, I would like Berlin Activities Depot to automatically pick you my student.

_____I would like my child picked up for early dismissals. I understand that an additional $25 Early Dismissal Fee will apply.

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:** _____

ALL MEMBERS MUST HAVE THIS FORM COMPLETED TO BE CONSIDERED FOR ENROLLMENT

BERLIN ACTIVITIES DEPOT

BEFORE & AFTER SCHOOL PROGRAM

2019-20

LEARN

PLAY

ENGAGE

(410)629-0878

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