PRESCHOOL CAMP AT THE EARLY LEARNING CENTER

SPANISH CAMP

A great opportunity for your young child to learn Spanish through games and student-centered activities. This class will include hands on activities such as games, songs, crafts, and stories in Spanish.

CRN: 25482 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	6/21-6/23
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

ART TO THE EXTREME

Jump into the world of art and release your inner artist! We will use our hands, feet, and imaginations to create amazing works of art using a variety of art materials. Clear some room on your walls because you want to hang these up.

CRN: 25483 **Tuition:** $65 **Fee:** $35

Tues/Wed/Thu	6/28-6/30
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

TAKE A DIVE!

Make the ocean come to life in this week long camp. Learn about the ocean and the creatures that live within. Get ready for a splashing good time.

CRN: 35103 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	7/5-7/7
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

PIRATE CAMP FOR CAPTAINS

Welcome to HCC's Pirate Cove where all the pirates will gather for a brand new adventure. Pirates aboard our ship will make a compass rose, telescope, and their very own parrot. We will discover the many places pirates explored and make a treasure map like that of a true pirate explorer. Be prepared for the culmination of our festivities with face painting and an exciting treasure hunt with unforeseen riches as your reward. Yo Ho, Ho . . . it's a Pirate Camp for you!

CRN: 35105 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	7/12-7/14
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

SUGAR & SPICE

This camp is everything nice. Treat your child to a week of princesses, fairies, butterflies and flowers. We will even have a teddy bear picnic and tea party! This class will open the imagination through music and movement, arts and crafts, and, of course, story time.

CRN: 35104 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	7/12-7/14
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

YOUNG EINSTEINS SCIENCE CAMP

Join us for an extremely fun week of messy, gooey, slimy science projects. We will create edible, explosive, and ooey gooey experiments that are sure to blow your mind!

CRN: 35106 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	7/19-7/21
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

MARVEL VS. DC

Are you team Spiderman or team Hulk? It doesn't matter, Superheroes UNITE! Join us for a fun filled week of fighting crime and capturing those villains who *are trying to destroy our universe!*

CRN: 35107 **Tuition:** $65 **Fee:** $35

TUES/WED/THU	7/26-7/28
9 AM-12 PM	Sessions: 3
Early Learning Center	Ages 3-4

To register for Early Learning Center Preschool Camps contact Jen Eder at jdeder@harford.edu or 443.412.2393.

HARFORD COMMUNITY COLLEGE

Registration Form

MAIL TO
Harford Community College
Noncredit Registration
401 Thomas Run Road, Bel Air, MD 21015
P: 443.412.2376 | F: 443.412.2383

Office Use Only

☐ **Spring** ☐ **Summer** ☐ **Fall**

Registered by: _____
Cashier's Office: _____
C/R _____ Ini. _____ Date _____
Waiver: ☐ Yes E D S

YES, please contact me in the event of an emergency on campus or a non-emergency campus closing.

H

HCC ID | Last Name | First Name | MI

Street | City | State | Zip Code

Home Phone ☐ Cell ☐ Work Phone | Email ☐ Personal ☐ Work

Contact Information for Harford Community College AlertMe Emergency Notification System

☐ **YES,** please contact me in the event of an emergency on campus or a non-emergency campus closing. _____ *Preferred contact phone number*

☐ **NO,** I choose not to be contacted in the event of a campus emergency or non-routine campus closing.

Date of Birth _____ *month date year* **Senior Citizen** (60 years or older) ☐ YES ☐ NO **Gender** ☐ Male ☐ Female

Citizenship ☐ U.S. Citizen ☐ Permanent Resident/Asylee/Refugee *(Must bring in original card.)*
☐ Non-U.S. Citizen *(Must submit copy of immigration document.)* Visa Type: _____

Ethnicity Are you of Hispanic or Latino origin? ☐ YES ☐ NO
(Defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Race Select one or more of the following categories: ☐ White (01) ☐ Black/African American (02) ☐ Asian (03) ☐ American Indian or Native Alaskan (04) ☐ Native Hawaiian or Other Pacific Islander (05)
(See harford.edu/dfr for definitions of race.)

How did you hear about this course?

☐ Newspaper ☐ Radio ☐ HCC Marquee ☐ HCC Website ☐ Schedule of Classes ☐ HCC Camp Curiosity Program Booklet
☐ Email ☐ Postcard/Flyer/Brochure ☐ HCC Social Media ☐ Referral from Family or Friend ☐ Referral from Instructor
☐ Other _____

COURSE #	COURSE TITLE	TUITION	FEE	OUT-OF-COUNTY SURCHARGE $20	OUT-OF-STATE SURCHARGE $35	COST
					SUBTOTAL	
WAIVER ELIGIBILITY:					**WAIVER TOTAL**	
					TOTAL COST	

Payment is due at time of registration.

☐ Check ☐ Money Order
☐ VISA ☐ MasterCard
☐ Discover ☐ American Express

We will contact you for payment by credit/debit card as soon as your registration has been processed.

I accept and agree to abide by the policies and regulations of Harford Community College. I understand that violation of these regulations may subject me to penalties and sanctions. (A copy of the Student Code may be obtained from the Student Activities Office.) I certify that the information on this form is accurate and complete. Failure to provide accurate information may be just cause for dismissal from the College.

_____
Signature *Date*

NOTE: Photographs may be taken in classrooms and/or on campus and used for Harford Community College promotions including, but not limited to, use on Facebook, the College website, and print materials. If you do not wish to be photographed, please inform the photographer.

REV. 03/28/18

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 https://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 https://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 Testing Certificate must be signed by a health care practitioner stating a questionnaire was done.

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

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for 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 https://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 Last Name _____ First _____ Middle _____ Birth Date _____ Sex: ☐ Male ☐ Female

Street _____ City _____ State _____ Zipcode _____

Parent/Guardian Name(s)	Relationship	Phone Numbers		
		W:	C:	H:
		W:	C:	H:
Your Child's Routine Medical Care Provider Name: Address: Phone:	**Your Child's Routine Dental Care Provider** Name: Address: Phone:	**Last Time Child Seen for** Physical Exam: Dental Care: 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.

Parent/Guardian's Signature _____ Date _____

Part I - Health Assessment

To be completed ONLY by Physician/Nurse Practitioner

Child's Last Name _____ First _____ Middle _____ Birth Date _____ Sex: ☐ Male ☐ Female

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** 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	☐	☐	☐	LeadExposure/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's 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	Result		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
Lead Test Indicated: DHMH ☐ 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 of 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) _____ (City) _____ (State) _____ (Zip code)

Sex: ☐ Male ☐ Female **Birth Date:** _____ **Phone:** _____

Parent/Guardian Name: _____ (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/Guardian Name _____ Parent/Guardian 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 ☐ School Health Professional/Designee

_____ Provider Name _____ Signature _____ Date

_____ Office Address _____ Phone

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/Guardian Name _____ 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

_____ Office Address _____ Phone

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
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229

Baltimore Co. (Continued)
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
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
20712
20731
20737
20738
20740
20741
20742
20743
20746

Prince George's (Continued)
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
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.

Maryland Department of Health Immunization Certificate

Child's Name: _____ (Last) _____ (First) _____ (Middle)

Sex: ☐ Male ☐ Female **Birth Date:** _____ **County:** _____

School: _____ **Grade:** _____

Parent/Guardian: _____ (Name) _____ (Phone)

_____ (Street) _____ (City) _____ (State) _____ (Zip code)

Record of Immunizations *(see notes on next page.)*

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
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

1. _____ (Signature) _____ (Title) _____ (Date)

Medical provider, local health department official, school official, or child care provider only.

2. _____ (Signature) _____ (Title) _____ (Date)

3. _____ (Signature) _____ (Title) _____ (Date)

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

Clinic/Office Name
Office Address and Phone Number

Complete the appropriate section below if the child is exempt from vaccination on medical or religious grounds. Any vaccination(s) that have been received should be entered above.

Medical Contraindication:

Please check the appropriate box to describe the medical contraindication.
This is a: ☐ Permanent condition ☐ 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: _____ (Medical Provider/LHD Official) _____ (Date)

Religious Objection:

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

Signed: _____ (Date)

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except varicella, measles, mumps, or rubella.

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but revaccination may be more expedient.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

1. Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;

2. Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and

3. Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e)Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the **"Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools"** to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index.)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index.)

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

Emergency Form

CACFP Enrollment: ☐ Yes ☐ No

Meals your child will receive while in care:
☐ BK ☐ LN ☐ SU ☐ AM Snk ☐ PM Snk ☐ Evng Snk

Instructions to Parents/Guardians:

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: _____

Child's Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip code)

Enrollment Date: _____ Hours & Days of Expected Attendance: _____

Parent/Guardian Name(s):

1. _____ (Name) _____ (Relationship) _____ (Place of Employment)

   _____ (Home Phone) _____ (Cell Phone) _____ (Work Phone)

2. _____ (Name) _____ (Relationship) _____ (Place of Employment)

   _____ (Home Phone) _____ (Cell Phone) _____ (Work Phone)

Name of Person Authorized to Pick up Child *(daily)*:

_____ (Last Name) _____ (First Name) _____ (Relationship to Child)

_____ (Street Address) _____ (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. _____ (Last Name) _____ (First Name) _____ (Home/Cell Phone) _____ (Work Phone)

   _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

2. _____ (Last Name) _____ (First Name) _____ (Home/Cell Phone) _____ (Work Phone)

   _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

3. _____ (Last Name) _____ (First Name) _____ (Home/Cell Phone) _____ (Work Phone)

   _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Child's Physician/Source of Health Care: _____ (Name) _____ (Phone)

Address: _____ (Street) _____ (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.

_____ (Parent/Guardian's Signature) _____ (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: _____ Birth Date: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

Emergency Medical Instructions

1. Sign/symptoms to look for: _____

_____

2. If signs/symptoms appear, do this: _____
3. To prevent incidents: _____

_____

Other special medical procedures that may be needed:

Comments:

Note to Health Practitioner

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

_____ _____

Name of Health Practitioner Date

_____ _____

Signature of Health Practitioner Phone Number

Enrollment Releases and Medical Information

I am a legally competent adult who is parent or guardian of the named participant. I would like my child to participate in Harford Community College Early Learning Center programming and expressly give my permission. I understand that even when every reasonable precaution is taken, incidents and accidents may occur. Therefore, in exchange for the Harford Community College Early Learning Center allowing my child to participate, I voluntarily and intentionally hold harmless and release Harford Community College's HCC Early Learning Center, and Harford Community College and the Behavioral and Social Sciences Division, their agents, employees, and volunteers from any and all actions, causes of actions, liability, claims, or demands for or by reason of damage, loss, or injury which may be sustained by my child as a result of his/her participation in this program. I also agree to indemnify the Harford Community College Early Learning Center for claims made by or for the participant or claims arising from any relationship with the participant or the participant's estate.

I have read this form and grant permission for my child, _____ ,to participate in all activities provided by Harford Community College Early Learning Center.

Parent/Guardian Signature: _____ Date: _____

Authorization For Emergency Medical Treatment

If my child, _____ , should become ill or injured during Harford Community College activities, I understand that Harford Community College will: 1) contact me immediately; 2) contact the person(s) I have designated in case I cannot be reached.

Should Harford Community College be unable to reach me or the person(s) designated, Harford Community College is authorized to contact my physician or arrange for immediate medical treatment to ensure the health and safety of my child, including the administration of medications or injections provided by me for such purpose.

I accept responsibility for payment of medical services rendered.

Parent/Guardian Signature: _____ Date: _____

Participant Waiver

I, _____ ,as parent/legal guardian for _____ ,

a minor residing at _____ , do hereby release and forever discharge Harford Community College's Early Learning Center, and Harford Community College and the Behavioral and Social Sciences Division, their agents, employees, and volunteers from any and all actions, causes of actions, liability, claims, or demands for or by reason of damage, loss, or injury which may be sustained by my child as a result of his/her participation in this program.

I, as parent/legal guardian for the above-named minor, give my permission for my child to go on field trips with the Harford Community College Early Learning Center program during the school year.

I, as parent/legal guardian for the above-named minor, give my permission for the persons in authority to secure emergency medical attention for my child if it is needed.

Parent/Guardian Signature: _____ Date: _____

These forms are required for your child to participate in any program.