# SAINT GEORGE GREEK PRESCHOOL
# COVID-19 PREVENTION AND SAFETY COVENANT

As a valued member of the Saint George Greek Preschool Community, I promise to support my child, the faculty and staff, and families and caregivers by practicing and adhering to the health and safety rules and policies outlined below so we can remain a safe, connected, and vibrant community where children can learn and grow together, cognitively, socially, emotionally, spiritually, and physically. I pledge the following as a parent or caregiver, faculty or staff member, as well as a Saint George Community Member who adheres to our community values of kindness, respect, responsibility, and honesty.

I am aware we are in the midst of a global pandemic. Any return to in-person instruction or other school activities involves the risk of contracting COVID-19. I understand that Saint George Greek Preschool is working with medical professionals and other advisors to implement safety measures and protocols to mitigate this risk.

**As a committed Parent/Caregiver and/or Faculty/Staff member, I will ensure:**

- All medical forms and immunization records for my child are updated and uploaded to CCB as required before school begins;
- All members in our household practice and discuss safe hygiene and hand washing methods on a regular basis;
- All members in our household practice wearing properly fitted masks to prepare our family and our children for the transition back to school; and
- All members in our household practice the Centers for Disease Control and Prevention (CDC)-recommended social distancing rules to prepare us and our Saint George Greek Preschool students for the transition back to school.

**As a committed Saint George Greek Preschool Community Member I will ensure that:**

- If my child is at increased risk for experiencing severe illness due to COVID-19, I will consult with a medical provider before they attend in-person activities;

- All members in our household abide by all applicable Saint George Greek Preschool rules and regulations, including any administrative decisions that may be warranted for safety reasons, and trust that the school is operating with the interests of all community members in mind;
- As a Faculty or Staff member, I too, abide by Saint George Greek Preschool's safety protocols to include consulting with a medical provider if I am at increased risk of illness due to COVID-19; taking my daily temperature, staying home if I feel sick or any household members present with COVID-19 symptoms; social distancing and wearing a mask and other PPE as necessary; and leaving the school premises due to COVID-19 or its symptoms, with return subject to Saint George Greek Preschool approval based on CDC and local health authority guidance;
- All members in our household abide by travel quarantine or other "close watch" restrictions imposed by federal, state, and/or local requirements;
- All members in our household wear properly fitted face masks at all times while on Saint George Greek Preschool's grounds and in the Preschool building;
- My child's temperature is taken daily before arriving at school;
- My child stays home if feeling sick or if my child, or any household members, present with any COVID-related symptoms as identified by the CDC, including cough, diarrhea, fatigue, fever, headache, muscle aches, nausea, or runny nose;
- As an urgent matter, a parent or designated caregiver is available to pick up my child within one hour or less if my child is required to go home due to health reasons;
- If my child is sent home due to COVID-19 or COVID-19 symptoms, my child will not return to school until Saint George Greek Preschool approves his/her return based on guidance from the CDC and local health authorities. While home, my child will access Saint George Greek Preschool's remote learning tools on our website.

Thank you for your continued support of our program and we look forward to seeing you and the children at school!

_____ _____

Childs's Name (printed) Parent/Caregiver Signature

_____ _____

Parent/Caregiver Name (printed) Date

St. George Greek Preschool

Bethesda, Maryland

# St. George Greek Preschool Photo Release Form

St. George Greek Preschool is making a concerted effort to promote the positive activities of our staff and students. This includes developing our website, advertising the school, and creating informational brochures. These publications may include images of our staff and students and their work. We do not publish student names. Please return this form so we know your preferences with respect to the use of such images.

**********

LAST NAME: _____

I hereby authorize St. George Greek Preschool to publish photographs taken of or student work created by the minor children named below for use in the St. George Greek Preschool website and/or printed publications.

I release St. George Greek Preschool from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize St. George Greek Preschool to use said photographs. Photos will consist of child actively learning and/or playing at St. George Greek Preschool or St. George Greek Preschool-related events (e.g. Christmas Program, Independence Day Program, End-of-Year Picnic, etc.), and will not include names.

## Permission

I acknowledge that since participation in publications and websites produced by St. George Greek Preschool is voluntary, neither the minor children nor I will receive financial compensation. I further agree that participation in any publication and website produced by St. George Greek Preschool confers no rights of ownership whatsoever. I release St. George Greek Preschool, its director, board members and employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

☐ I do authorize use of photos and student works for the below named St. George Greek Preschool student(s)

☐ I do not authorize use of photos and student work for the below named St. George Greek Preschool student(s)

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PLEASE LIST ALL CHILDREN CURRENTLY ENROLLED AT ST. GEORGE GREEK PRESCHOOL:

CHILD ONE: _____

CHILD TWO: _____

CHILD THREE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

St. George Greek Preschool

Bethesda, Maryland

## EMERGENCY INFORMATION

Child's Full name: _____

Child's First Greek Name: _____

Child's Date of Birth: _____

Home Phone number: _____

Mother's Name: _____

Mother's Emergency Phone Number (cell/work): _____

Father's Name: _____

Father's Emergency Phone Number (cell/work): _____

Name of close relative or family friend: _____

Telephone number of this person: _____

Name of student's Physician: _____

Telephone number of Physician: _____

Specify any allergies the School should know about:

_____

In case of emergency, your child will be transported to the nearest hospital unless you specify otherwise.

In an emergency, I wish my child to be taken to: _____

## PARENT ACKNOWLEDGEMENT

PARENT'S / GUARDIAN'S SIGNATURE SIGNIFIES FULL AGREEMENT WITH THE PROCEDURES AND CONDITIONS SPECIFIED ON BOTH THIS FORM AND THE PARENT HANDBOOK.

## CHILDREN PICK-UP AFTER SCHOOL CLASSES

Parents are required to pick up their children at the end of class session. The Greek School will charge a fee for any child being picked up late and after the above designated time. Specifically, for every five (5) minutes or portion thereof that the children are not picked up from school, the family of the child will be charged $5. Any fee imposed as a result of this action will be payable prior to the next class session.

**PARENT'S SIGNATURE :** _____

**DATE OF SIGNATURE :** _____

St. George Greek Preschool

Bethesda, Maryland

**Parent/Child Reunification Authorization for Release of Student**

Name of Student:_____Class(s)_____
Name of Student:_____Class(s)_____
Name of Student:_____Class(s)_____

I certify that I am the custodial parent/legal guardian of the above named student(s), and I grant permission for my child to be released to any of the following individuals at the end of the school day or in the event of an emergency/crisis that requires the school to release the students. (Each section must be completed.)

**My child may be released to the following individuals.** (Additional names may be included on a separate piece of paper. If additional names are attached parent/guardian must initial here:_____)

Name: _____ Relationship to child(ren): _____

Address: _____ Phone: _____

Name: _____ Relationship to child(ren): _____

Address: _____ Phone: _____

Name: _____ Relationship to child(ren): _____

Address: _____ Phone: _____

**Parent/Guardian Information:**

Parent/Guardian Name: _____ Home Phone:_____

Work Phone: _____ Cell Phone: _____

Parent/Guardian Name: _____ Home Phone:_____

Work Phone: _____ Cell Phone: _____

**I understand that my child will be released only to those listed on this form.**

**Parent Signature: _____ Date: _____**

# MARYLAND DEPARTMENT OF HEALTH 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 | MenB 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: _____

# 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

# 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.

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

**TREATMENT**

| **Symptoms:** The child has ingested a food allergen or exposed to an allergy trigger: | **Give this Medication** Epinephrine | Antihistamine |
|---|---|---|
| But is ***not*** exhibiting or complaining of any symptoms | | |
| Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny") | | |
| Skin: hives, itchy rash, swelling of the face or extremities | | |
| Gut: nausea, abdominal cramps, vomiting, diarrhea | | |
| Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough | | |
| Lung*: shortness of breath, repetitive coughing, wheezing | | |
| Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness | | |
| Other: | | |
| If reaction is progressing (several of the above areas affected) | | |

*Potentially life-threatening. The severity of symptoms can quickly change.
*__IMPORTANT:__ Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

| **Medication** | | **Dose:** |
|---|---|---|
| Epinephrine: | | |
| Antihistamine: | | |
| Other: | | |

_____ _____
Doctor's Signature Date

**EMERGENCY CALLS**

**1) Call 911** (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

| Contact(s) | Name/Relationship | Phone Number(s) Daytime Number | Cell |
|---|---|---|---|
| Parent/Guardian 1 | | | |
| Parent/Guardian 2 | | | |
| Emergency 1 | | | |
| Emergency 2 | | | |

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

# Allergy Action Plan
# (Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

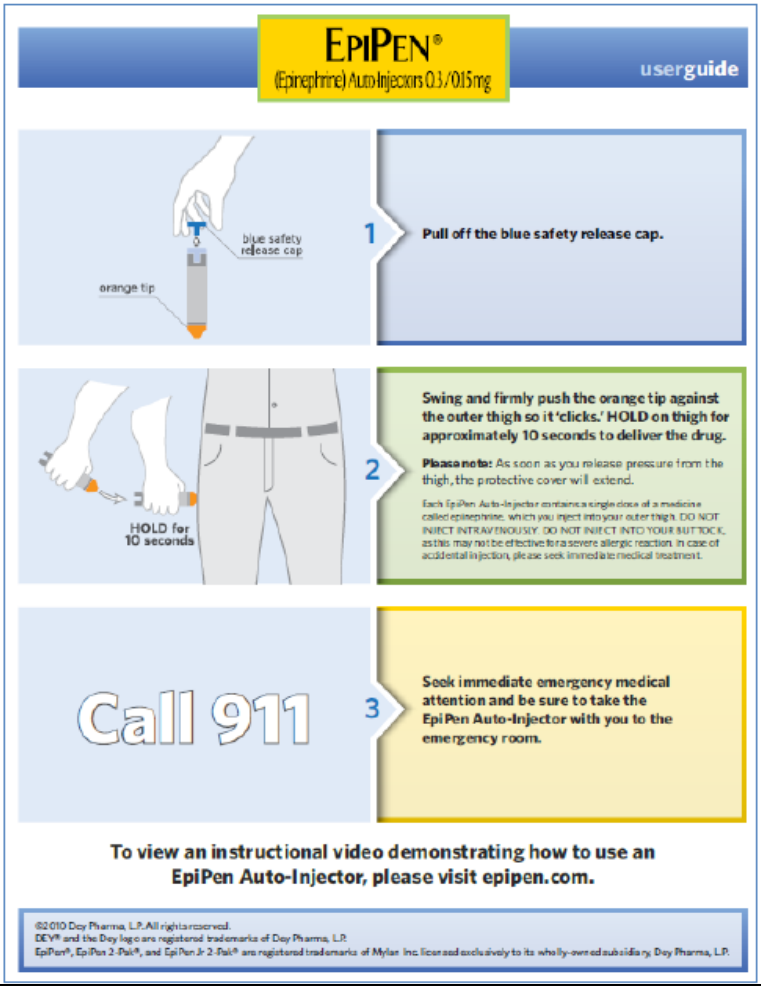
**CHILD'S NAME**: _____ **Date of Birth**: _____

**ALLERGY TO**: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

**The Child Care Facility will:**

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐




**The Parent/Guardian will:**

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐