Middletown United Methodist Church Preschool, PTO and Kids Club
7108 Fern Circle, Middletown, MD 21769
301-371-8681 preschool@mtownumc.org
301-371-8680 kidsclub@mtownumc.org

REGISTRATION FORM 2023/2024 SCHOOL YEAR

Child's Name:____
First Middle Last

Name to be learned at school (Nickname):________________________ Sex: Female or Male

Birthdate (mm/dd/yyyy):______________________________________ Age:_________________

Address:____
Street City State Zip

Does your child have an IFSP or IEP? ______ Will you share that information with MUMC? _____

Guardian 1

Name:____

Address:____
Street City State Zip

Email:____ May we share this with other parents? Yes__ No __

Employer (If Applicable):______________________________ Work Phone:________________________

Guardian 2

Name:____

Address:____
Street City State Zip

Email:____ May we share this with other parents? Yes__ No __

Employer (If Applicable):______________________________ Work Phone:________________________

Brothers/ Sisters with ages and other person(s) living in the household:

____

Has your child ever attended preschool? YES/ NO If, yes where and what class?

____

What Elementary/ Primary school will your child attend for kindergarten?

____

Please indicate the following **Preschool class** in which you wish to enroll your child. Please indicate 1st and 2nd choice. MUMC does not discriminate on the basis of race, religion, creed, sex, color, or national origin in the admission of its students.

Tuesday/ Thursday 2- year old class 9:00 am-12:00 at $250/ month ___________	**Monday/Wednesday/ Friday 2- year old class** 9:00 am-12:00 at $300/ month ___________
Tuesday/ Thursday 3- year old class 9:00 am-12:00 at $250/ month ___________	**Monday/ Wednesday/ Friday 3- year old class** 9:00 am-12:00 at $300/ month ___________
Monday/ Wednesday/ Friday 4- year old class 9:00 am-12:00 at $300/ month ___________	**Monday through Friday 4- year old class** 9:00 am-12:00 at $400/ month ___________
Monday through Friday 4- year old Extended Day Class (children will bring their own lunch) 9:00 am- 2:00 pm at $495/ month ___________	

Please indicate your preferences for **Kids Club Before and After Care** for the 2023/2024 school year.

Preferred Days:	**Total hours needed per week:**
Time in:	**Time out:**

Fee Agreement of Kids Club:
The number of hours you contract for must equal or exceed the number of hours scheduled above. Families are responsible for payment each week, whether their child does or does not attend. Each family is allowed one week of "vacation" per school year. Kids Club operates as a Before and After care and will be closed most days FCPS or MUMC preschool is closed. On the days we are open for all day-care when school is closed, you may be charged a higher rate if your child attends. Kids Club will no longer prorate for weeks that we have days off so your charge per week will remain the same unless your child uses more than the contracted hours in a given week. At this time, Kids Club hours are 7:00 am- 5:30 pm.

** The child who attends the most hours per week will be charged the First Child Rate.**

KIDS CLUB	**First Child**	**Sibling(s)**
30+ hours/wk	$155 ___________	$135 __________
20-30 hours/wk	$135 ___________	$120 __________
10-20 hours/wk	$115 ___________	$105 __________
0-10 hours/wk	$ 75 ___________	$ 70 __________

Parents Time Out (PTO) is for children aged 6 months-2 years (staff to child ratio 1:3) and 2-3 years old (some 4 year olds accepted, staff to child ratio of 1:6). Classes are offered T/TH or M/W/F. Snacks are provided. Please indicate which class you would prefer for **PTO**, you may put 1st and 2nd choice.

Infant / Toddler (6 month - 2 years old) PTO Class:

Monday/ Wednesday/ Friday 9:00am- 12:00pm $300/ month ____________	**Tuesday/ Thursday** 9:00am- 12:00pm $250/ month ____________

Preschool Aged PTO Class:

Monday/ Wednesday/ Friday 9:00am- 12:00pm $225/ month ____________	**Tuesday/ Thursday** 9:00am- 12:00pm $175/ month ____________

Children attending the 2 year old Preschool MUST be 2 before September 1st. They do not have to be potty trained. Parents will provide pull-ups and wipes throughout the year as needed.

Children attending 3 and 4 year old classes MUST be potty trained and able to use the bathroom independently. Children enrolling in the 3 and 4 year old classes should have their birthday by September 1st of the school year. Early entrance in a preschool class will be considered if a birthday falls within the 45 day grace period and the child is fully potty trained and is capable of being in a structured program.

Middletown United Methodist Church Preschool and PTO reserves the right to cancel any classes with inadequate enrollment. MUMC follows the FCPS school calendar regarding school closures and snow closures.

The registration fee covers registration cost and will reserve your space for the fall. Registration for this school year is $50 per family and is non- refundable.

A one- time activity fee of $150 (which helps cover the cost of Brightwheel, supplies, special events, and snacks for the school year) will be due on August 1st. The $150 activity fee is per child and is non-refundable.

Signature:____________________________ Date:____________________

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

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

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

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

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

Address: ______________________ Number Street Apt# City State Zip

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

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	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	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Disorder	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Printed Name and Signature of Parent/Guardian ______________________ Date

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

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

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

2. Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
☐ No ☐ Yes, describe:

4. Health Assessment Findings

Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Disorder	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. Is the child on medication?
☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. Should there be any restriction of physical activity in child care?
☐ No ☐ Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

10. **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: ____________________

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