REGISTRATION: $125

TUITION: $400/MONTH

We offer transportation to and from your child's elementary school.

PARTICIPATING SCHOOLS

Piney Branch
Sligo Creek
Takoma Park
East Silver Spring
Forest Knolls
Woodlin
Rolling Terrace
Rock Creek Forest

CONTACT

PHONE:
301-588-3350

WEBSITE:
www.QualityTimellc.com

EMAIL:
Info@qualitytimellc.com

SCHOOL-AGE ENRICHMENT

Quality Time Learning Center
8101 Georgia Avenue,
Silver Spring, MD 20910
301-588-3350

PROGRESS THROUGH PRODUCTIVITY

Bright, Active and Socially Competent,
Your school-aged child has precocious energy and intelligence which merits engagement in a variety of activities to expand their knowledge and provide challenging stimulation. Our programs foster independence, with homework help in private, advanced program enrichment center.

Quality Time recognizes the individuality of the maturing school-aged child, providing a nurturing learning environment of academics and play, infused with a sense of pride and community.

Quality Time is committed to the concept of equal opportunity through education. With a dedication to overall excellence in education, and our longstanding reputation in the community, we strongly advocate for the significance of early care and education in enhancing children's present and future quality of life.

Quality Time Learning Center

(ALL FORMS MUST BE COMPLETELY FILLED OUT IN ADVANCE BY PARENTS AND YOUR CHILD'S DOCTOR IN ORDER FOR YOUR CHILD TO START SCHOOL

Quality Time Learning Center

School-Age Enrichment Program

8101 Georgia Avenue
Silver Spring, MD 20910
301-588-3350

Requested date for Enrollment:
_____/_____/_____
AGE___
School Attending: ____________

REGISTRATION APPLICATION

Child's Name:____ ID#_____
First M.I. Last

Home Address:____

____

Gender: Male:___ Female:___ Child's D.O.B. ____/____/____ Age: _____

Requested Date for Enrollment: ____

Mother/Guardian's: First Name:__________________M.I.:___Last Name:__________________
Home Address:____Mobile: ______________
Employed by:_________________________ Occupation:______________Work Hours: _______
Work Address: ____
Office Phone: ( )____________________ E-mail: ______________________________

Father/Guardian: First Name:__________________M.I.______Last Name:__________________
Home Address:____Mobile: ______________
Employed by:_________________________ Occupation:______________Work Hours: _______
Work Address: ____
Office Phone: ( )____________________ E-mail: ______________________________

Are parents divorced or separated? ____
With whom does the child reside? ______________Who has legal custody of child? __________
Languages spoken at home: ______________ ______________ ______________
Brother's/Sister's:____
Dates of Birth:

___ ___ ___ ___ ___ ___ ___ ___ ___
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

List any existing medical conditions, allergies and/or special attention your child may require:____

____

(For those emergencies requiring immediate attention, I understand and agree that my child will be taken to Holy Cross Hospital)

Mother's Signature: ________________________________ **Date:** ______________

Father's Signature: ________________________________ **Date:** ______________

2023-2024

Quality Time Learning Center

(School Age/Before & After Care)
8101 Georgia Avenue, Silver Spring, MD 20910
Tuition Contract (Five-Year-Olds and Older)
September 5, 2023 – June 7, 2024

Tuition for my child (first name)______________________(last name)____________________DOB ____/____/____ is $ ____________ (monthly). This rate remains in effect from **September 5, 2023, until June 7, 2024**. During this period, I will make monthly payments according to the tuition payment schedule attached. _____ (Parents Initials)

1. **Payment Methods:**

- Checks, Money Orders, and certified funds are acceptable forms of payment. Tuition must be paid monthly. Monthly payments that are not paid (see Tuition Payment Schedule (TPS) attached) on time shall incur a late fee of $60.00 for payments received late up to three business days after the payment is due. A $100.00 late fee will be charged for late payments made after the third day late. _____ Tuition which is more than two weeks past due may cause your child to be dropped from the program and his/her slot to be allocated to another child. Late Tuition, Late Pick-up and Returned check Fees are automatically billed to your account without exception. Requests to waive fees may be made through the waiver appeal process. _____ Checks returned by your bank for any reason shall incur a $75.00 returned check charge. Future payments may be requested in cash or certified funds. Any tuition, registration or re-registration paid in advance will not be refunded.
- All accounts must be paid-in-full on or before December 19, 2023, before returning on January 3, 2024.
- **All Kindergarten through Fifth Grade accounts must be paid in full before winter break and spring break. All Kindergarten through Fifth Grade tuition fees, etc., must be paid-in-full to avoid suspension by Tuesday, May 9, 2023.**
- A non-refundable registration/registration fee of $95.00 for 5-year-olds and above should be paid in advance of your child entering our program. Any money given by a parent will be applied in the following manner: Registration first, all other fees for monthly payments and finally, tuition. Any time a parent in our program formally withdraws, they must pay a re-registration fee to re-enroll. A re-registration fee of $95.00 for 5 year-olds and above must be paid annually. Re-registration is charged annually upon the commencement of each contract year. _____ (Parent Initials)
- **Process for suspending child/ren for failure to pay fees:** (For discipline related suspensions please refer to suspension guidelines for details).
  If payment is not received within 72 hours of the due date, a warning letter will be sent to the parent. If payment is not received after the 1st warning letter, a 2nd letter will be sent. The 2nd letter will include a demand for payment in full or the child will be suspended. The child shall remain suspended until payment is received in full. The parent will remain responsible for tuition during the suspension period. No reduction is made for suspended or expelled child/ren for any reason._____
- For a family enrolling more than one child, QTE reserves the right to apply any money received toward the family account to any child in the family as it sees fit. Accordingly, a delinquent account on any child in the family may trigger a suspension or expulsion of all children enrolled. _____
- No reduction in tuition is made for vacations, illnesses, holidays, weather related emergency closings or for any reason the school may need to close all day, close early and open late.
- **Contract Start Date**: The parent is obligated to begin paying tuition on the Contracted Start Date (CSD) September 5, 2023, and will therefore be invoiced as of the CSD without exception. A parent's failure to attain all required enrollment information and submit them properly does not void the CSD. Should a space not be available on the CSD the Center will refund all monies including the registration fee, unless the Center makes it known otherwise at the time of contract signing.
- Any monies not paid according to the terms of this contract will be subject to legal action. _____. If this course of action is taken, you will be liable for all court costs. Collection companies are under contract with QTE to collect outstanding debts.
- During a suspension period, all tuition is due and should be paid on time to avoid **penalties**.

2. **QTE's Hours/Late Pick-up:**

- The Center's hours of operation are 7:00 a.m. to 6:00 p.m. Parents are requested to be prompt in picking up their child. Your account will be charged a late fee of $2.00 per minute after 6:00 p.m. until 6:30 p.m. Habitual late pick-ups may cause suspension. Late pick-up fees after 6:30 p.m. will be $3.00 per minute. Late pick-up fees must be paid-in-full by close of business the next business day or the late pick-up fee will double.(Parent's Initials_____) In case of inclement weather, if the Center closes early, late pick-up fees will be applied after the early closing time of the inclement weather day. All siblings enrolled in our program, including those who may be in different buildings, must be picked up by 6:00 p.m. Late fee will be applied after 6:00 p.m. and will apply to the latest child picked up. For parents who pick-up their child late more than three times in any 30 day period, a fee schedule of $5.00/minute late fee may be charged. Suspension and/or expulsion may also be applicable. Legal authorities (such as; Protective Services, etc.,) will be contacted for children not picked up after one hour of QTE closing, i.e., at 7:00 p.m. Parents who fail to confirm with the school their late pick-up before 6:00 p.m. will pay double the normal late pick-up fee. Parents not dropping off their child by 9:05 a.m. each morning will be charged a $2.00 per minute late drop-off fee, in addition to a $3.00 per minute fee for children dropped off after 9:20 a.m. Late drop-off fees apply to each sibling in the family ______. Only children with a doctor's note will be admitted after 10:00 a.m. ______.

Quality Time Learning Center
(School Age/Before & After Care)
8101 Georgia Avenue, Silver Spring, MD 20910
Tuition Contract (Five-Year-Olds and Older)
September 5, 2023, - June 7, 2024

Inclement Weather:
- If Montgomery County Public Schools have a 2-hour delay, there will be no Before Care and **parents are responsible for transporting their child to school**. If Montgomery County Public Schools are closed, QTE will be closed. If there is an impromptu closing by Montgomery County parents are responsible for picking up. (Parent's Initials_____)

3. **Promotional Advertisement for Enrollment**:
   - From time to time, in order to boost enrollment during an "off-peak" period, QTE may run special promotions. At these times, discounted rates may be offered that are lower than the rates parents may be paying. These promotions do not entitle already contracted parents to any promotional discounts. QTE continues to have a very high demand for its services. We always want to be in the position to offer our services to parents who weekly meet their financial obligations to the school. Parent's failure to remain current in their tuition may be given two weeks notice prior to dismissal. Full tuition payment is expected during this notice period. In the event of re-enrollment, the child will be placed on the waiting list. Parents will then be given notice of an opening. Promotional, advertisement and discount rates will change to regular rates when, a. your balance is not current for more than two weeks, and b. your checks are returned (insufficient funds) for more than three times. (Parent's Initials_____)

4. **Withdrawing/Returning/Other:**
   - Parents withdrawing their child from the program for any reason (medical, financial, etc) must give a 30 day written notice for withdrawal and may be required to pay a re-registration fee should they re-enter the program at a later date. Parents failing to provide a 30 day notice will be required to forfeit one week of tuition. (Parent's Initials_____)

5. **Behavior/Discipline/Suspension Policies:**
   - Certain behavior and discipline related matters may cause your child's immediate suspension and or expulsion from the school. For more comprehensive details refer to our Suspension Guidelines. (Parent's Initials_____) No reimbursements of any funds/payments (including payments made in advance) will be made if your child's behavior is the cause of suspension or expulsion from school. (Parent's Initials_____)

6. **Students Records.**
   - All forms must be completed and returned before the child enters the program. All forms should be updated whenever there are any changes in parents/guardian information (e.g., phone numbers, change of address, medical, etc.). (Parent's Initials_____)

7. **Abiding by School Policies:**
   - **Parents are expected to respect and uphold school policies and regulations and the contractual agreement they have with the school. QTE reserves the right to ask parents to remove their child from the school if said parents disregard or fail to uphold school policies, regulations, or terms of the contractual agreement they have with QTE. All deposits, tuition, and any other fees paid in advance are non-refundable for a parent who is expelled from the school.(Parent's Initials_____)**

THIS CONTRACT SUPERSEDES ALL PREVIOUS CONTRACTS

I/We undersigned, have read and fully understand, and agree to comply with the tuition contract/fee, scheduled policies of QT Enrichment.

Contract Start Date: _____/_____/______ QTE will start billing on ______/_______/______ (parent's initials ______)

Fees Paid:	**Cash**	**Check**	**Money Order**	**ATM**	**On-Line**
Registration	____	_____	______________	_______	_______
Tuition	____	_____	______________	_______	_______

Mother/Guardian Signature: ____ Social Security [ ] [ ] [ ]

Father/Guardian Signature: ____ Social Security [ ] [ ] [ ]

Signature of Financially Responsible Person: ____ Date: _____/_____/_____

Print Name of Financially Responsible Person: ____ Date: _____/_____/_____

Signature of Director: ____ Date: ____/_____/_______

Quality Time Learning Center
School-Age Enrichment
8101 Georgia Avenue
Silver Spring, MD 20910

EMERGENCY CONTACT, PICK-UP PERSON(S) AND CHILD RELEASE AUTHORIZATION FORM

This document is the sole authority for pick-up/release of your child. The following people are authorized to visit my child at school and to pick-up my child from QT Enrichment:

Child's Name: (FIRST)________________(Last) _______________ Nick Name:________________
Address: ____
____
Birth Date: ______/_____/_____

Mother's/Guardian'	**Father's/Guardian's**
Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
______________________	______________________
Phone: (H) ______________________	Phone: (H) ______________________
Employer: ______________________	Employer: ______________________
Phone: (W) ______________________	Phone: (W) ______________________
Cell Phone: ______________________	Cell Phone: ______________________

(Authorized Pick-Up People Other than Mother and Father)

Name: ______________	Name: ______________	Name: ______________
Address: ______________	Address: ______________	Address: ______________
______________	______________	______________
Phone: (H) ______________	Phone: (H) ______________	Phone: (H) ______________
Phone: (W) ______________	Phone: (W) ______________	Phone: (W) ______________
Cell Phone: ______________	Cell Phone: ______________	Cell Phone: ______________
Relationship: ______________	Relationship: ______________	Relationship: ______________

(Please use the back of this form for more names)

In case all above named authorized people cannot pick-up your child, parents must call the school before 5:00 p.m., and provide us the name/s and phone number/s of other alternate pick-up person/s. Parents are responsible for ensuring that the persons who are authorized to pick-up a child from the Center are aware of their responsibilities, e.g., having picture I.D. at the time of pick-up, and must be 16 years old or older. (LEGAL AUTHORITIES E.G. POLICE AND CHILD PROTECTIVE SERVICES WILL BE CONTACTED FOR CHILDREN LEFT AT QTE ONE HOUR AFTER CLOSING THE CENTER, i.e., AT 7:00 P.M.) ______________ (Mother's initials/date and Father's) ________________.
Note: For any change in Emergency Contact pick-up person(s), Parent/Guardians are responsible to update the information as soon as changes occur. We must have your updated phone number(s) at all times.

The Center is **NOT** authorized to release the child to the following people.

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

Mother's/Guardian's Signature: ______________________________ **Date:** ____/_____/_____
Father's/Guardian's Signature: ______________________________ **Date:** ____/_____/_____

***Unless amended in person by the signing parent between September 5, 2023 to June 14, 2024.**

Quality Time Learning Center
School-Age Enrichment

MEDICAL CARE AND EMERGENCY CONTACT INFORMATION

Child's Name: ______________________________ D.O.B. ____________________

Address: ____

Mother's Name: ______________________ (H) ______________ (W) ______________

Father's Name: ______________________ (H) ______________ (W) ______________

Alternate Emergency Contact:

Name: ______________________ (H) ______________ (W) ______________

Name: ______________________ (H) ______________ (W) ______________

Child's Physician: ______________________ (Ph) ______________________

Family Physician: ______________________ (Ph) ______________________

Child's Medical History:

Known allergies of child (medicine, food, etc.):

1.______________________ 3.______________________

2.______________________ 4. ______________________

Describe past serious illnesses or hospitalization, with date:

____

____

Medications taken by child at this time:

1.______________________ 3. ______________________

2. ______________________ 4.______________________

Describe all physical conditions or illnesses which could affect the child's participation in the programs or medically diagnosed conditions which prohibit participation in normal day care activities (diabetes, epilepsy, insufficient blood coagulation, etc.):

____

____

EMERGENCY MEDICAL TREATMENT CONSENT

(Must Be Notarized)

I hereby give **QTE** permission to provide first aid care as deemed necessary for my child, ______________________________. In the event I/We cannot be reached, I hereby authorize **QTE** to transport my child to the emergency room of the hospital(s) listed below. I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which the physician deems necessary (including anesthesia). I have specified any hospital(s) below, my child may be taken to and/or the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

Nearest Hospital: ***Holy Cross*** Alternate ______________________

Parent/Guardian: ______________________________ Date: ______________

Parent/Guardian: ______________________________ Date: ______________

of ______________________________, County of ______________________

SUBSCRIBED AND SWORN TO BEFORE ME THIS ______day of ______________________, 20 ______

NOTARY PUBLIC______________________________ My Commission Expires: ______________

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

Child's Name: ______________________________ Birth date: __________ Sex
Last First Middle Mo / Day / Yr 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

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 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:

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: ______________________________

____

____

____

Note to Health Practitioner:

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

CACFP Enrollment: Yes:___ No:____

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(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	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

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 ____________

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete.*

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: ____

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.

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
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr

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

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

Clinic / Office Name
Office Address/ 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 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: ______________

Maryland State Department of Education
Office of Child Care

Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.
Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's Picture Here (optional)

PRESCRIBER'S AUTHORIZATION

Child's Name:______________________________ Date of Birth: ___/_____/_____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from:___/___/_____ to ___/___/_____

If PRN, for what symptoms, how often and how long______________________________

Possible side effects and special instructions:______________________________

Known Food or Drug Allergies: ☐ Yes ☐No If yes, please explain:______________________________

For School Age children only: The child may self-carry this medication: ☐ Yes ☐No

The child may self-administer this medication: ☐ Yes ☐No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer** ☐ **Yes** ☐ **No**

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date ___________ ☐ Yes ☐ No
2. Medication labeled as required by COMAR. ☐ Yes ☐ No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐ No ☐N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐ No ☐N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

Maryland State Department of Education
Office of Child Care
MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				Date of Birth:	
Medication Name:				Dosage:	
Route:				Time to Administer:	
DATE ADMINISTERED	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Quality Time Learning Center

COVID-19 Parent Orientation

General Information

- **Phases** Modified hours to start. Increased hours as phases change. Less academic focus, more health and safety practices.
- **Philosophy** Health and safety practices. Forming and enforcing habits. New protocol.
- **Sick Policy** Daily health check and questionnaire. Fever 100.4 or greater. Coughing. Sneezing. 72-hour exclusion from center after call for pick-up.
- **Hours** 8:00 a.m. – 5:00 p.m. Prices- Regular tuition costs. Payment process.
- **Suspensions**
- **What is Different** Group size. Teacher. Classroom.

Children's Information

- **Children 3 years and older are required to have mask or face covering**
- **Lunches must be disposable**
- **Extra set of clothing (bagged and labeled) to stay at school**
- **Hand sanitizer**
- **Clean bedding each day**
- **Wear clean clothes each day**

Teacher Information

- **COVID-19 Training** Opening and closing classroom procedure. Signed agreement.
- **Quality Control Personnel** Monitor teacher: child interaction. Classroom procedures.
- **Health** Daily health and temperature checks.
- **Uniforms** Mask/face covering. Gloves when appropriate and necessary. Clean clothing/ less skin exposure.
- **Daily Activities** Less physical contact.
- **Emotional support** through words. (Reading/storytelling. Increased screen time).
- **Roaming Oversight** Ensuring frequent disinfecting and sanitizing procedures are followed.
- **Parent Communication** Daily sheets each day. Messages can be sent to teachers through ClassDojo.
- **Lunchbreaks** Staff will not be permitted to leave the premises.
- **Hygiene** Spray bottles. Water pitchers. Bathroom schedule.

Parent Must

- **Be willing** to make change. Be patient.
- **Pack disposable lunch**. No refrigeration. No warming of food. No lunch boxes.
- **Personal Thermometer** Must take child's temperature upon arrival and present to child care staff for record keeping.
- **Drop-off and Pick-up** Procedures No parents allowed in building or on soft surface of the playground. **Must wear mask/facial covering.**
- **Must not** receive other children at pick-up.

Administrative

- Monitor health and safety program
- Monitor absenteeism of teacher and children
- Ensure supplies are available
- Make adjustments to policy as needed
- Keep parents informed via daily reports, pictures and ClassDojo

Next Steps

- Sign, date and return this form
- Complete questionnaire
- Pay registration
- Provide letter of employment

I have attended COVID-19 Parent Orientation on ....
I understand all policies and procedures outlined in the orientation and will comply with all areas covered. I acknowledge that I have completed the COVID -19 Questionnaire truthfully and will comply with all sick policy rules and reporting procedure.

Furthermore, I understand and agree that it is completely up to the school's administration to suspend or expel my child from the center due to any matter they deem related to health and safety of my child, other children and or staff. This judgment is completely discretionary on the part of the administration and to be complied with /without objection. In the event of suspension, all tuition will remain in effect and due according to the tuition payment schedule. Tuition for expulsion must be paid through theend of the expelled week plus a oneweek penalty.

Child's Name____ Child's D.O.B________________

Parent Signature____ Date__________________

<u>Parent Orientation Commitment Agreement</u>

Upon entering Quality Time Learning Center, the parent or guardian of each student shall attend a parent orientation.

The purpose of the orientation is to form a partnership with parents thereby establishing a strong connection for the benefit of nurturing and educating the children entrusted to our care. We understand how important it is for you to know about your child's day, upcoming events, and progress in all areas of your child's learning and development. We know that consistent communication is the key to a trusted partnership with parents.

Based on these facts, we begin our partnership at Quality Time with a **parent orientation.** Having a clear understanding up front of what we can expect from each other helps us establish common goals for the benefit of your child. These goals create an important foundation for forming the very best early childhood education experience for you and your child.

We will conduct one (1) parent orientation each month throughout the 2022-2023 school year. Please indicate below the date you are committed to attend, sign and return the Parent Orientation Commitment Agreement at the end of this page.

______________________________ ______________________

Parent/Guardian Signature Today's Date

______________________________ ______________________

Center Representative Today's Date

Parent Orientation Commitment Date: __________________

Parent Orientation Commitment Date: __________________

Time: _________________

COVID-19 Questionnaire

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.

Have you experienced **any** of the following in the last 14 days:

Symptoms	Yes	No	Explain
Cough			
Shortness of breath			
Difficulty Breathing			
Fever			
Chills			
Muscle pain			
Sore throat			
New loss of taste			
New loss of smell			
Nausea			
Vomiting			
Diarrhea			

Has **any** member in your household tested positive for COVID-19 or quarantined in the last 14 days? Yes_ No_ If yes, what date? ________ Next appointment date to be retested__________

Is **any** member in your household being quarantined for a possibility of COVID-19? Yes_ No_ If yes,explain____

____

Are any members in your household showing any symptoms of COVID-19? If yes, please explain____

____

Has **any** member of your household who did not have symptoms, **but** tested positive quarantined at least 14 days? Yes__ No__

___ I will report any COVID- 19 related issues pertaining to **any** member of my household to Quality Time Learning Center promptly.

Child' Name____ Date________________

Parent Name______________________________ Signature_____________________________________

Subject to Change

On days when Quality Time has a delayed opening there will be no Before Care. No After Care will be provided on days that QT Enrichment will close early. Parents must provide all after school snack.

QT Enrichment - School Age Enrichment Program
Schedule of Operations
2023 – 2024 School Year

Days that MCPS will CLOSE but QTE will OPEN:

QTE will operate from 7:00 a.m. to 6:00 p.m. on these days

September 25, 2023	No School for Students & Teachers
November 1, 2023	No School for Students & Teachers
January 29, 2024	No School for Students & Teachers
February 15&16, 2024	No School for Students & Teachers
March 25, 26, 27, 28, 2024	No School for Students & Teachers
May 15, 2024	No School for Students & Teachers

Early Release Days

QTE will be open from dismissal time until 6:00 p.m. on these days

September 22, 2023	Early Release
November 20, 21, 22, 2023	Early Release
March 1, 2024	Early Release

Days that MPCS will be Closed and QTE will be Closed

September 4, 2023	Labor Day
October 9, 2023	Indigenous People's Day
November 10, 2023	Veteran's Day
November 23, 24, 2023	Thanksgiving Holidays
***December 25-29, 2023**	**Winter Break**
January 1, 2024	New Year's Holiday
January 2, 2024	New Year's Day (Observed)
January 15, 2024	MLK, Jr. Holiday
February 19, 2024	President's Day
***March 25 - April 1, 2024**	**Spring Break**
May 27, 2024	Memorial Day

QT Enrichment Program will begin on September 5, 2023 (first day of school) and will end June 7, 2024.

If the school year is extended beyond June 7, 2024, QT Enrichment may extend its program as well.

***Separate Accommodations may be available for children.**