REGISTRATION : $150.00

TUITION: $230.00 BI-WEEKLY

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

PARTICIPATING SCHOOLS

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

School-Age Enrichment

Quality Time Learning Center
8101 Georgia Avenue, Silver Spring, MD 20910
www.QualityTimellc.com
Email: info@qualitytimellc.com
Tel: 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:** _____

Quality Time Learning Center

(School Age/Before & After Care)
8101 Georgia Avenue, Silver Spring, MD 20910
Tuition Contract (Five-Year-Olds and Older)
August 26, 2025 – June 5, 2026

Tuition for my child (first name)_____(last name)_____DOB ___/___/____ is $ _____ (monthly). This rate remains in effect from **August 26, 2025, until June 5, 2026**. 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. All credit and/or debit card/merchant payments will incur a $4.00 convenience fee per transaction either on-line, by telephone, and/or in person. Tuition must be paid monthly. All 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 12, 2025, before returning on January 5, 2026.
- **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 5, 2026.**
- A non-refundable registration/registration fee of $150.00 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 $150.00 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, QTLC 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) August 26, 2025, 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 QTLC to collect outstanding debts.
- During a suspension period, all tuition is due and should be paid on time to avoid **penalties**.

2. **QTLC'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 QTLC 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)
August 26, 2025, - June 5, 2026

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, QTLC 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, QTLC 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. QTLC 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_____)
   - If a family is receiving childcare subsidy financial support, or not and subsequently find their child expelled, then the same family must forfeit one week of subsidy or pay one week out of pocket before a Change of Provider form is approved. _____

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. QTLC 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 QTLC. 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'

Name: _____
Address: _____

_____

Phone: (H) _____
Employer: _____
Phone: (W) _____
Cell Phone: _____

Father's/Guardian's

Name: _____
Address: _____

_____

Phone: (H) _____
Employer: _____
Phone: (W) _____
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 August 26, 2025, to June 5, 2026.**

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:

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 Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
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 or immunizations, 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 Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
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:

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*

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 DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of >3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention: https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

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 _____

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1													
2													
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4													
5													

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

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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: _____

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

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
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: _____

Quality Time Learning Center
8101 Georgia Avenue, Silver Spring, MD 20910
Telephone: 302-588-3350 Fax: 301-588-6006
Email: info@qualitytimellc.com
Website: www.QualityTimellc.com

PARENT ORIENTATION PLAN - CHECKLIST

Name of Facility: _____

Welcome! Selecting childcare is important to families. It is very important that parents are oriented to the childcare program where their child is receiving services. Knowing and understanding the policies and procedures of the childcare program can have a positive impact on families and their childcare experience.

This is your orientation checklist. We will be sharing information with you about our center, and we are also providing you with a copy of the center's policies and procedures. This orientation is intended to help you understand what you need to know as you leave your child in our care. We plan to cover all areas listed below with you. If an area is not covered or if you do not receive a copy of the policies and procedures, please be sure to let us know.

- ☐ Regular communication with parents
- ☐ Daily information to be shared with parents about infants and toddlers
- ☐ Parent access to children while in the center
- ☐ Parent-teacher conferences
- ☐ Information about resources/services for children with different abilities and needs
- ☐ Confidentiality
- ☐ Daily attendance
- ☐ Drop-off and parking
- ☐ Transportation (how supervision and safety are handled)
- ☐ Discharge procedures
- ☐ Release of children to authorized person
- ☐ Withdrawal procedures
- ☐ Items to be provided by parents and provider
- ☐ Procedures to contact parent when child is sick
- ☐ Emergency medical care
- ☐ Illness and injury
- ☐ Allergies
- ☐ Communicable diseases
- ☐ Medication
- ☐ Meals and nutrition
- ☐ Daily activities
- ☐ Field trips
- ☐ Discipline policies and techniques
- ☐ License
- ☐ Ratios, group size and supervision
- ☐ Payments for childcare services

Quality Time Learning Center
8101 Georgia Avenue, Silver Spring, MD 20910
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Email: info@qualitytimellc.com
Website: www.QualityTimellclcom

- ☐ Fees when child is absent
- ☐ Late pick-up fees
- ☐ Fees for late payment
- ☐ Additional fees (field trips, insurance, transportation, etc.)
- ☐ Non-discriminatory policy
- ☐ Alcohol and drug policy
- ☐ Non-smoking policy
- ☐ Pets

My signature below indicates that I have received a copy of the center's policies and procedures, and an orientation was conducted with me which covered all areas outlined in this orientation plan.

Parent Signature: _____ Date: _____

QTLC Staff: _____ Date: _____

Child's Name .....

NO BEFORE AND AFTER CARE ON - October 13th (Indigenous Peoples' Day) and November 11th (Veteran's Day) QTLC will be CLOSED Early Release for MCPS

On days when Quality Time has a delayed opening there will be no before care. No aftercare will be provided on days that QTLC will close early. Parents must provide all after school snack.

Quality Time Learning Center

School Age Enrichment Program
Schedule of Operations
2025 – 2026 School Year

Days that MCPS will CLOSE but QTLC will OPEN:
(QTLC will operate from 7:00 a.m. to 6:00 p.m. on these days)

September 23, 2025	No School for Students & Teachers
October 2, 17, 20, 2025	No School for Students & Teachers
November 3, 26, 2025	No School for Students & Teachers
January 26, 2026	No School for Students & Teachers
February 17, 2026	No School for Students & Teachers
March 20, 2026	No School for Students & Teachers
May 27, 2026	No School for Students & Teachers

Early Release Days
QTLC will be open from dismissal time until 6:00 p.m. on these days

January 27, 28, 2026	Early Release

Days that MPCS will be Closed and QTLC will be Closed

September 2, 2025	Labor Day
November 11, 2025	Indigenous Peoples' Day
November 27 & 28, 2025	Thanksgiving Holidays
December 23, 2025 – January 5, 2026	**Winter Break**
December 24-26, 2025	**Christmas Holiday Break**
January 1, 2026	New Year's Holiday
January 19, 2026	MLK, Jr. Holiday
February 16, 2026	President's Day
March 30, - April 6, 2026	**Spring Break**
May 25, 2026	Memorial Day

QTLC Enrichment Program will begin on August 26, 2026 (first day of school) and will end on June 5, 2026.

If the school year is extended beyond June 5, 2026. QTLC Enrichment will consider extending its program.