creative Journeys
CHILD CARE LEARNING CENTER

WELCOME!

We want to thank you for choosing Creative Journeys Learning Center for your preschool and childcare needs. Our staff is committed to providing a quality preschool program to the Edgewood APG community. Our family-centered services are an extension of the love your family provides to your child.

Our philosophy is that children should be allowed to grow at their own pace and to learn in ways that help them become confident in themselves as learners. Our curriculum, The Creative Curriculum for Preschool, prepares children to enter Maryland pre-school and Kindergarten programs at the top of their class! The curriculum guides our entire program and has two goals:

- To help children learn about themselves and the world around them
- To encourage children to feel good about themselves and capable as learners

A safe place for children to explore and learn. Our center has been professionally designed to fit your child's needs. Our center is structured and organized as a safe place for children to explore and learn. You'll notice children's toys and materials on low shelves. All children will also have a place to keep their personal belongings. This helps children make choices and develop independence.

Our activity schedule gives children daily structure. Children feel secure when they know that every day I will read to them before naptime or that after snack we go outside. Our schedule also allows for times when we all do things together, such as music, and times when the children are doing things on their own, such as coloring and playing with toys.

Creatively, we learn while playing. We have developmentally appropriate activities for children. We build with blocks, color, make arts& crafts, put puzzles together, read and tell stories, play with sand and water, cook, dance to music, and play outdoors. All activities are aimed at helping children do thing on their own, be curious, and stay interested in all that's going on around them.

We value working in partnership with parents. Open and honest communication is key to the development of your child. Please know that we are here for you and your entire family through various community resources offered to your children at our center.

Again, thank you for choosing Creative Journeys Learning Center. We look forward to providing your family with the best possible care your child.

The Creative Journeys Staff

423 Edgewood Rd • Edgewood, MD 21040 • 410-676-9002 • www.CreativeJourneysChildCare.com

Where the Journey of Life Begins

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CHILD CARE LEARNING CENTER

ENROLLMENT AGREEMENT

Child's Name _____ Child's Name _____

Child's Name _____ Child's Name _____

Parent's Name _____

Child care services will begin on _____, 20 _____.

The hours for care will begin at _____ and end at _____ on the following days:

_____

TUITION FEES

$ _____ per week for full time care.

$ _____ per hour for regular part-time care.

$ _____ per hour for drop-in care if space is available.

Child care fees are payable in advance on Friday prior to the week care is provided. A $20 late fee will be charged for all late payments, thereafter a $5 late fee is assessed daily. Fees may be paid weekly or bi-weekly. A convenience fee may be assessed for payments other than cash, check, or money order.

NOTICE: A two-week written notice is required for any of the following:
(Multiple sibling families require a 3 week notice)

1. Termination of the agreement by either party.
2. Increases in child care fees.
3. Vacation periods for families.

I/We fully understand and agree to the terms of this contract.

Parent/Guardian signature: _____ Date _____

Parent/Guardian signature: _____ Date _____

Director's signature: _____ Date _____

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CHILD CARE LEARNING CENTER

ENROLLMENT FORM

1. Parent/Guardian Name:__________ Relationship: __________

Street Address:__________City:__________State:_____ Zip: _____

Employer: __________

Home Phone:__________Cell Phone: __________Work Phone: __________

Email: __________Preferred method of contact: __________

2. Parent/Guardian Name:__________ Relationship: __________

Street Address:__________City:__________State:_____ Zip: _____

Employer: __________

Home Phone:__________Cell Phone: __________Work Phone: __________

Email: __________Preferred method of contact: __________

Child's Name: __________ Date of Birth: __________
Attendance: ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri **Meals:** ❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack

Child's Name: __________ Date of Birth: __________
Attendance: ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri **Meals:** ❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack

Child's Name: __________ Date of Birth: __________
Attendance: ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri **Meals:** ❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack

Child's Name: __________ Date of Birth: __________
Attendance: ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri **Meals:** ❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack

Emergency Contact Information *If parents cannot be reached.*

1. Name: __________ Relationship: __________

Street Address:__________City:__________State:_____ Zip: _____

Phone: __________ Email: __________

2. Name: __________ Relationship: __________

Street Address:__________City:__________State:_____ Zip: _____

Phone: __________ Email: __________

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Family/Home Information

Other Family Members: Relation to Child (ren):

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:
In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to transport my child to:

Physician: _____ Address: _____ Ph: _____
I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.

PERMISSION FOR ACTIVITIES:
I/We hereby give Creative Journeys Learning Center permission to take my/our children off the premises and on excursions that will take place during regular childcare hours. I understand that I will be notified of any such trips beforehand, that trips will be supervised and that all precautions will be made for the safety and well being of all children. _____

I/We hereby give Creative Journeys Learning Center permission to take my/our children on walks daily as part of the scheduled curriculum. _____

I/We hereby give Creative Journeys Learning Center permission to use baby wipes, diaper rash ointment or other items necessary that I have provided. _____

I/We hereby give Creative Journeys Learning Center permission to take photos of your child during daily activities. ____

My/Our child has permission to sleep on a cot (or in a crib for infants) during rest time. _____

Signature – Parent or Legal Guardian Date

_____ _____

_____ _____

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CHILD CARE LEARNING CENTER

Information About Your Child

Please help us know more about your child.

Favorite toys, playthings, Blanket, special toy, or play interests:_____

_____

_____

How does he or she communicate?_____

_____

_____

Favorite foods: _____

_____

_____

Allergies, and/or food restrictions, or special dietary needs: _____

_____

_____

Medications taken regularly: _____

_____

Naptimes and routines: _____

_____

General disposition/fears/comforting: _____

_____

Favorite songs/games/finger plays:_____

_____

Family's guidance approach: _____

_____

Additional information which may be helpful in understanding your child, his or her needs, and in making the transition to this child care program easier: _____

_____

_____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf*
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐

Last First Middle Mo / Day / Yr

Address: _____

Number Street Apt# City State Zip

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

Where do you usually take your child for routine medical care? Name:

Address: **Phone Number:**

When was the last time your child had a physical exam? Month: **Year:**

Where do you usually take your child for dental care? Name:

Address: **Phone Number:**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, etc.)

☐ No ☐ Yes, what procedure(s):

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

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

Signature of Parent/Guardian Date

To be completed *ONLY* by Physician/Nurse Practitioner

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

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	**WNL**	**ABNL**	**Not Evaluated**	**Health Area**	**WNL**	**ABNL**	**Not Evaluated**
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)

RELIGIOUS OBJECTION:

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

Parent/Guardian Signature: Date:

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: ☐Yes ☐ No		

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below 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.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219

Baltimore (cont)
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
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
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781

Prince George's (cont)
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL