



Please enroll my child for the 2021-2022 school year. I understand that in order to reserve space for my child I must pay the **non-refundable** registration fee along with this form. I also understand that Stepping Stones Preschool reserves the right to accept or decline enrollment of my child.

(Parent's Signature)

(Date)

INSTRUCTIONS

1. Please complete one form per child.
2. Attach a separate payment for each form complete.

Student's Name _____
(Last First Middle)

Child resides with Mother Father Both

Home Address _____	Date of Birth _____
City/State/Zip _____	
Home Phone () _____	
Father's Name _____	Mother's Name _____
Driver's License _____	Driver's License _____
Home Address _____	Home Address _____
City/State/Zip _____	City/State/Zip _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Email Address _____	Email Address _____

Will your child need the following fee-based options?

Early Stay

Late Stay

Name of church you attend _____		
Attendance is	Faithful	Occasional Seldom
Church's Address _____		
City/State/Zip _____		
Pastor's Name _____		Church Phone # _____



GETTING TO KNOW YOU

What is your name? _____

Do you have a nickname? What is it? _____

What is your favorite color? _____

What is your favorite treat/snack? _____

How many people are in your family? _____

Do you have a favorite animal? _____

Do you have a pet? What is his/her name? _____

Do you like to sing? What songs? _____

Are you ticklish? _____

What was your favorite vacation? _____

STATEMENT OF FAITH

The basis for Stepping Stones Preschool and Daycare can be found in the Word of God interpreted by the following nine essentials:

1. We believe in the verbal inspiration and authority of the Scriptures. The King James Version of the Bible reveals God, the fall of man, the way of salvation, and God's plan and purpose for the ages. *Note: All students must use a KJV of the Bible.*
2. We believe there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.
3. We believe in the Deity and Virgin Birth of our Lord Jesus Christ, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, and His ascension to the right hand of the Father.
4. We believe in the visible, personal, and pre-millennial return of Jesus Christ.
5. We believe that salvation is "by grace" plus or minus nothing. The conditions to salvation are repentance and faith in Jesus Christ.
6. We believe that man is sinful and thereby separated from God. He is justified by faith alone and accounted righteous before God only through the merit of our Lord and Savior, Jesus Christ.
7. We believe in the resurrection of both the saved and the lost: the saved unto the resurrection of life and the lost unto the resurrection of damnation.
8. We believe in the eternal security of the believer in Christ.
9. We believe in the local church with the ordinances of baptism by immersion and the Lord's Supper.

MISSION AND PURPOSE OF STEPPING STONES PRESCHOOL & DAYCARE

Our goal is to assist parents and the church, by providing a quality, Christian education for young people that will encourage them to receive Jesus Christ as their personal Saviour and will motivate them to commit their lives to stand for Him in today's world.

COMMITMENT OF STEPPING STONES PRESCHOOL & DAYCARE

We are committed to families. We are privileged to serve God's creation, the family, and to assist parents in training their children.

We are committed to maintaining a safe and secure environment for our children and to challenge them daily in the Word of God.

We are committed to churches. We affirm the mission of a Bible-believing church, and of discipling people for Christ. We support local churches by encouraging loyalty to their ministries and by emphasizing the value of the life spent in the Gospel ministry in all of its facets.

We are committed to our students. We are bound by love to watch for their souls, to train our students in truth and righteousness, to protect and prepare them, to show them the way of salvation in Jesus Christ, to convey a Biblically-based and quality education, to demonstrate the Christian life in our words and actions, and to imitate the love of God in our relationships with them.

We are committed to our faculty. We are committed to provide an environment that allows them to minister freely and effectively, to encourage and honor excellence in the classroom, and to support their work with prayer and materials that will assist them in their efforts to strengthen their ministries.

We are committed to our community. As long as we are in the world, our name will be associated with honesty and integrity in our performance, concern for and submission to civil authority, and educated citizens who will make positive contributions to society in their role as salt of the earth. We will strive to present a testimony that will not shame the name of our Lord Jesus Christ.

PARENT STATEMENT OF COOPERATION

Parents of students Stepping Stones Preschool and Daycare must agree to the following statements:

1. I realize it is the function of the school to assist parents in carrying out their God-given responsibilities in rearing their children.
2. I know that the school is the final authority on all matters of dress and grooming, and I agree to help the school enforce its dress code by sending my child(ren) to school dressed and groomed according to the dress code.
3. I give permission for my child to take part in all school activities, including school-sponsored trips away from the school premises. I absolve the school from all liability in the event that my child is injured during any school activity or at school. I am aware that for me to chaperone field trips I must adhere to the school's dress code.
4. I am aware that my cooperation is expected in regular tuition payments. If I am ever unable to pay on time, I will notify the school office giving a reasonable explanation for the delay, and state when the payment can be made.
5. If I feel I am at odds with Stepping Stones Preschool and Daycare's school policies, I promise to go directly to the school office and seek to resolve the matter right away. If I do not agree with the policies in the handbook specifically the discipline system, I will not try to change the policies, but will withdraw my child quietly and without delay.
6. I realize that the school has full discretion in the discipline of my child while he/she is under the supervision of the school. I understand and concur with the discipline steps of the school. I also realize the school will administer no form of corporal discipline.
7. If for any reason my child does not respond favorably to the discipline and academic systems of the school, I will not try to change the school to fit his/her needs, but will withdraw my child quietly, and without delay.
8. Realizing tardies disrupt the class, embarrass the child, and cause him/her to get behind in his morning work; I will strive to be on time except in an emergency. Realizing any absence from school hinders my child's academic progress, I will only allow him/her to miss school in times of emergency, illness, or doctor's appointments.
9. I have read the Statement of Faith and I am willing to have my child trained according to it. I commit to pray for the school and its leaders.
10. I know that the administration reserves the right to withdraw any student from Stepping Stones Preschool and Daycare at any time in the event the actions of the child or parent causes the administration to question the integrity of the student or parent.

Father's Signature _____

Date _____

Mother's Signature _____

Date _____

Student's Name: _____

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



Dear Parents,

All students are required by the Maryland Department of Health and Mental Hygiene to have an updated shot record in the school office.

Since the 2014-2015 school year, immunization requirements in the state of Maryland have changed for the students entering kindergarten and Grade 7.

As a result, **ALL** students, who will be enrolling in school for the 2021-2022 school year, must receive two (2) doses of the Varicella (Chicken Pox) Vaccine.

The enclosed form must be used to get an updated shot record from your doctor. Please submit an updated shot record to the school office along with all other records that have been requested. A list of all the shot requirements for each age group is attached.

Students have twenty (20) calendar days after the start of the 2021-2022 school year to present medical verification of receiving the required vaccinations. In the event the documentation is not presented, the student will not be allowed in school until the required records have been provided.

Students will not be able to attend school unless updated records are turned into the office.

Your help in this matter is greatly appreciated.

Sincerely,

Andrew Fridenstine
Stepping Stones Director

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

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

- **A physical examination by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care.** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The Immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:

http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

Evidence of Blood-Lead Testing for children living in designated at risk areas. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

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

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

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

INSTRUCTIONS

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

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

<http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf>

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

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address: _____ Last First Middle			Mo / Day / Yr		
Number Street		Apt#	City	State	Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
		W:	C:	H:	
		W:	C:	H:	
Your Child's Routine Medical Care Provider Name: Address: Phone #		Your Child's Routine Dental Care Provider Name: Address: Phone		Last Time Child Seen for Physical Exam: Dental Care: Any Specialist :	
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?					
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____					
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____					
Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____					
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Signature of Parent/Guardian _____			Date _____		

PART II - CHILD HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Child's Name: <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Last First Middle </div>	Birth Date: <div style="border-bottom: 1px solid black; margin-bottom: 5px; display: flex; justify-content: space-between;"> Month / Day / Year </div>	Sex M <input type="checkbox"/> F <input type="checkbox"/>
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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmvh_896_-_february_2014.pdf)

RELIGIOUS OBJECTION:

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

Parent/Guardian Signature: _____ Date: _____

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

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

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

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %ile		
Lead Test Indicated: DHMH 4620 <input type="checkbox"/> Yes <input type="checkbox"/> No	Test #1 Test #2	Test # 1 Test #2

_____ has had a complete physical examination and any concerns have been noted above.

(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:
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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: <input type="checkbox"/> Male <input type="checkbox"/> 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)

<u>Allegany</u>	<u>Baltimore Co.</u> <u>(Continued)</u>	<u>Carroll</u>	<u>Frederick</u> <u>(Continued)</u>	<u>Kent</u>	<u>Prince George's</u> <u>(Continued)</u>	<u>Queen Anne's</u> <u>(Continued)</u>
ALL	21212	21155	21776	21610	20737	21640
	21215	21757	21778	21620	20738	21644
<u>Anne Arundel</u>	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		<u>Garrett</u>	<u>Montgomery</u>	20752	<u>Somerset</u>
21225	21229	<u>Charles</u>	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	<u>Harford</u>	20812	20782	<u>St. Mary's</u>
	21237	20662	21001	20815	20783	20606
<u>Baltimore Co.</u>	21239		21010	20816	20784	20626
21027	21244	<u>Dorchester</u>	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	<u>Frederick</u>	21082	20868	20790	
21085	21286	20842	21085	20877	20791	<u>Talbot</u>
21093		21701	21130	20901	20792	21612
21111	<u>Baltimore City</u>	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	<u>Howard</u>	<u>Prince George's</u>	<u>Queen Anne's</u>	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	<u>Caroline</u>	21758		20712	21620	<u>Washington</u>
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						<u>Wicomico</u>
						ALL
						<u>Worcester</u>
						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.

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**

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.

Child's Picture (Optional)

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects & special instructions: _____

Medication shall be administered from: _____ to _____

Known Food or Drug: Allergies? Yes No If Yes, please explain _____
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/we certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL
(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____

Signature

Date

Parental approval: _____

Signature

Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Health Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____

Signature of Person Receiving Medication and Reviewing the Form

Date

1

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

[illegible]



Dear Parents,

We are working hard to make our Preschool the best it can be! In doing so, we post pictures on Facebook and our website of fields trips and special events that we have in class.

We are requesting your permission to post your child's picture for Stepping Stones advertising purposes. Please mark the appropriate box, sign and date this permission slip below. This document needs to be returned to the office as soon as possible.

We need a separate permission slip for each child. If you have any questions or concerns, please let us know.

Thank you so much!

Andrew Fridenstine
Stepping Stones Preschool Director



☐ I am **willing** to let my child's pictures be used on the school's Facebook page and website.

☐ I am **NOT willing** to let my child's picture be used on the school's Facebook page and website.

Child's Name _____ Date _____

Parent's Signature _____ Date _____



2021-2022 FINANCIAL SCHEDULE

Effective June 2021

REGISTRATION FEE- \$125.00

This fee includes student insurance. The registration fee is due with the application and is non-refundable.

TUITION- \$680.00 per month Additional siblings: \$600.00 per month

-Tuition payments are due on the 1st of each month and will be set up as an automatic payment through the Gradelink system. If you have any questions regarding setting up automatic payments, please see the office.

-There is a \$60.00 service charge for any check returned from the bank. Any account having a check returned will be placed on a cash or money order basis for the remainder of the year.

-If a past due payment as well as Early and Late Stay fees have not been received by the tenth of the month, a child will not be allowed to attend preschool until his/her account has been brought up to date. No financial adjustments can be made because of absences.

BOOKS AND MATERIALS FEE- \$100.00/per year

EARLY AND LATE STAY

The Early Stay program runs from 7:00 am-8:00 am each school morning

The Late Stay program runs from 3:30 pm- 6:00 pm each afternoon. The cost for these services is:

	Per Use:	Discounted Monthly Rate:
Early Stay:	\$8.00/hour	\$100/month
Late Stay:	\$8.00/hour	\$200/month

A late fee of \$10.00 for the first five minutes and \$1.00 per minute will be charged for each student not picked up 6:00 pm. Stepping Stones reserves the right to cancel Early/Late Stay if there is little or no interest.

All fees are subject to change at the discretion of the Stepping Stones Preschool and Daycare

Academic Ministry of Independent Baptist Church · 301.856.1616 · 9255 Piscataway Road Clinton, MD 20735

Pastor: T. Michael Creed

Preschool Director: Mr. Andrew Fridenstine

Daily Schedule K3

8:00 – 8:30	Arrival
8:40 – 8:50	Morning Circle (Calendar & Jobs)
8:50 – 9:10	Bible
9:10 – 9:20	Bathroom Break
9:20 – 9:40	Snack
9:40 – 10:10	Phonics / Handwriting
10:10 – 10:40	Recess
10:40 – 10:50	Bathroom Break
10:50 – 11:10	Language Development
11:10 – 11:30	Centers (M) / Numbers (T-F)
11:30 – 11:40	Bathroom Break
11:40 – 12:10	Lunch
12:10 – 12:30	Recess
12:30 – 12:50	Skills Development
12:50 – 1:00	Story/Reading
1:00 – 2:30	Nap
2:30 – 2:50	Bathroom / Snack
2:50 – 3:00	Review
3:00 – 3:30	Dismissal

K4 Daily Schedule

8:00-8:30	Arrival/Attendance (Activity Bins)
8:30-8:50	Pledges/Weather/Calendar/Morning Jobs
8:50-9:00	Bathroom Break
9:00-9:20	Recess Indoor-Gymnasium Outdoor-Playground
9:20-9:30	Bathroom Break
9:30-9:45	Morning Snack
9:45-10:15	Circle Time Songs/Bible Story
10:15-10:40	Table Time Phonics/Language/Hand Writing
10:40-10:50	Bathroom Break
10:50-11:20	Centers Science/Reading/Dramatic Play
11:20-11:30	Bathroom Break
11:30-12:10	Lunch
12:10-12:30	Table Time Math/Science & Social Studies
12:30-12:50	Recess Indoor-Classroom Outdoor-Playground
12:50-1:00	Bathroom Break
1:00- 1:15	Circle Time (Story Telling)
1:15-2:45	Nap Time
2:45-2:55	Bathroom Break
2:55-3:30	Review/Pack-up and Departure



PRESCHOOL SUPPLY LIST	
QUANTITY ITEMS NEEDED:	
1	SMALL blanket and SMALL pillow for nap time with a bag to store them in
2	Plastic pocket folders
1	Change of uniform – labeled with child’s name
1	Book bag that will close completely (must fit a lunch box, extra uniform, folder, and bedding)
1	Lunch box (OPTIONAL) – pictures and designs must be in agreement with academy philosophies and teachings
1	Coloring book – <i>to be used as needed in the classroom</i>
2	22 g glue sticks (large)
2	Boxes of 24 crayons – K4 only
1	4-pack of Play Dough
1	Reusable Water bottle
1	package of Jumbo crayons – K2 and K3 only
All student supplies need to be labeled with the child’s name.	



2021-2022 School Calendar

(dates subject to change)

August 2021

August 13

Half Day: Family Fun Day and Promotion Ceremony

August 16-20

No School: Teacher Training and Certifications

August 19

Parent Orientation

August 23

First Day of School

September 2021

September 6

No School: Labor Day

September 13

Grandparent's Day Breakfast

October 2021

October 5-6

School Pictures

October 27

Fall Festival

November 2021

November 4

Picture Retakes

November 11

No School: Veteran's Day

November 23

Thanksgiving Lunch

November 24-26

No School: Thanksgiving Break

December 2021

December 17

Christmas Party

December 20-31

No School: Christmas Break

January 2022

January 3

School Resumes

January 3

Re-enrollment Begins

January 17

No School: Martin Luther King Jr. Day

January 31

Open House 2:00-4:00 pm

February 2022

February 4

Kids on a Mission

February 14

Valentine's Day Party

February 21

No School: President's Day

March 2022

March 14 – 18

No School: Spring Break

April 2022

April 4

Open House 2:00-4:00 pm

April 8

Easter Egg Hunt

April 15-18

No School: Easter Break

May 2022

May 3

Teacher Appreciation Day

May 30

No School: Memorial Day

June 2022

June 1-3

Summer Teacher Work Week

July 2022

July 4

No School: July 4th

**FRENCH
TOAST**

SCHOOLBOX



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Independent Baptist Academy**

Your web store is now open!

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homepage to have coupon codes emailed to you.

Any questions?

Reach out to your dedicated French Toast Schoolbox Customer Service Team at
800-636-3104.

We look forward to serving you!

