St. Ursula School/Extended Day Program
8900 Harford Road
Baltimore, Maryland 21234
410-665-3533

April 2018

Dear Parents,

Below are the new rates for before and after care. All current school families who are intending to use Extended Day **must registe**r for next year no later than **April 27, 2018**. Extended Day will begin September 5, 2018. ***If you do not register by April 27 you will not be able to start until September 17th.*** Registration information is attached and can also found on the school website (www.stursula.org) under the "Admissions" tab. Please return all forms in an envelope marked "Niki – Extended Day."

Sincerely,

Debbie Glinowiecki	Niki Thoericht	Suzanne Wood
Principal	Extended Day Co-Directors	

SAINT URSULA SCHOOL EXTENDED DAY INFORMATION SHEET

Hours of Operation:

7:00 a.m. – 7:45 a.m.

2:50 p.m. – 6:00 p.m.

Registration Fees

Registration fees are non-refundable

One child	$20.00
Two children	$30.00
Three or more children	$35.00

Current Fees Beginning September 2018:

AM:	$7.00 per morning	$28.00 per week
PM:	$12.00 per afternoon	$50.00 per week
AM & PM:	$70.00 per week	

2018-2019

ST. URSULA EXTENDED DAY REGISTRATION

Student's Name_____(M) (F) Grade_____

Student's Name_____(M) (F) Grade_____

Student's Name_____(M) (F) Grade_____

So that we may bill correctly, please indicate the plan that best suits your childcare needs.

_____ **PLAN I** AM ONLY (Monday - Friday 7:00am-7:45am)

_____ **PLAN II** PM ONLY (Monday - Friday 2:50pm - 6:00pm)

_____ **PLAN III** AM/PM (combination of Plan I and Plan II)

* * * * * * * * * * * * *

_____ **PLAN IV** AM PART TIME

_____ Monday _____ Tuesday _____ Wednesday

_____ Thursday _____ Friday

_____ **PLAN V** PM PART TIME

_____ Monday _____ Tuesday _____ Wednesday

_____ Thursday _____ Friday

_____I have read the *Guide to Regulated Child Care* that was included with this registration packet.

Attached is my non-refundable registration fee made payable to Saint Ursula Extended Day.

Parent's Signature_____Date_____

2018-2019

SAINT URSULA EXTENDED DAY
AUTHORIZATION FORM

Student's Name _____ **Grade** _____

Student's Name _____ **Grade** _____

Student's Name _____ **Grade** _____

The following people are authorized to sign out my child(ren) from Saint Ursula Extended Day Program. Please have the person(s) listed below bring a photo ID. Please include all parents/guardians.

1. **Parent/Guardian (please print)**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

   Email Address _____

2. **Parent/Guardian (please print)**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

   Email Address _____

List below others who are eligible for pick-up other than parent/guardian

* * * * * * * * * * * * * *

3. **Print Name**_____**Relationship**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

4. **Print Name**_____**Relationship**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

5. **Print Name**_____**Relationship**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

6. **Print Name**_____**Relationship**_____

   Home Phone _____ **Work Phone** _____ **Cell** _____

EXTENDED DAY HEALTH QUESTIONNAIRE
2018-2019

****Please complete one form in full for each child being registered.**

Student Name and Grade: _____

Parent Contact Information: _____

Mother: _____

Home Phone: _____ Work: _____

Cell: _____ Email: _____

Father: _____

Home Phone: _____ Work: _____

Cell: _____ Email: _____

1. Does your child have any medical conditions which should be brought to our attention:

No _____

Yes _____ (If yes, please complete #2)

2. If yes, please list below information regarding your child's condition. An Extended Day staff member will contact you to follow up regarding treatment, medication, additional required paperwork, etc. If additional space is needed, please continue on a separate sheet of paper.

_____

_____

_____

_____

_____

_____

_____

_____

For questions, concerns or to file a complaint contact your regional office

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8770
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worchester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

Resources

Child Care Subsidy - Assists parents with cost of childcare

1-866-243-8796

Consumer Product Safety Commission (CPSC) - regulates certain products used in childcare

cpsc.org

Maryland EXCELS - Maryland's Quality Rating System for Childcare Facilities

marylandexcels.org

Maryland Developmental Disabilities Council - May assist with ADA issues

md-council.org

Maryland Family Network - Assists parents in locating childcare

Marylandfamilynetwork.org

PARTNERS Newsletter - What's happening in the Division of Early Childhood Development

Earlychildhood.Marylandpublicschools.org

To this site to check provider inspection violations

checkccmd.org

Maryland State Department of Education
PREPARING WORLD CLASS STUDENTS

Larry Hogan, Governor

Karen B. Salmon, Ph.D.
State Superintendent of Schools

OCC 1524 (8/2016)

Guide to Regulated Child Care

Important Information About Child Care Facilities

Who Regulates Child Care?

ll child care in Maryland is regulated by the Maryland tate Department of Education, Office of Child Care's OCC), Licensing Branch.

he Licensing Branch's thirteen Regional Offices are esponsible for all regulatory activities, including:

Issuing child care licenses and registrations to child care facilities that meet state standards;

Inspecting child care facilities annually;

Providing technical assistance to child care providers;

Investigating complaints against regulated child care facilities;

Investigating reports of unlicensed (illegal) child care; and

Taking enforcement action when necessary.

OMAR Regulations and other information about the ffice of Child Care may be found at:

arlychildhood.marylandpublicschools.org/child-care-roviders/office-child-care

What are the types of Child Care Facilities?

Family Child Care – care in a provider's home for up to eight (8) children

Large Family Child Care– care in a provider's home for 9-12 children

Child Care Center – non-residential care

Letter of Compliance (LOC) – care in a child care center operated by a religious organization for children who attend their school

All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

Did You Know?

- Regulations that govern child care facilities may be found at: earlychildhood.marylandpublicschools.org/regulation
- The provider's license or registration must be poste in a conspicuous place in the facility;
- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnigl care;
- Parents/guardians may visit the facility without pri notification any time their children are present;
- Written permission from parents/guardians is required for children to participate in any and all off property activities;
- All child care facilities must make reasonable accommodations for children with special needs;
- A "Teacher" qualified person must be assigned to each group of children in a child care center;
- Staff:child ratios must be maintained at all times ir child care centers;
- Parents/guardian must be immediately notified if children are injured or have an accident in care;
- Child care facilities may have policies beyond regulatory requirements;
- OCC should be notified if a provider has violated c care regulations;
- Parents/guardians may review the public portion licensing file; and
- The provider's compliance history may be reviewe on CheckCCMD.org.

One per child

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(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	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

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 _____

One per child

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

All students if applicable

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: _____

Child's Picture (Optional)

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.**

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: _____ (Month / Day / Year) to _____ (Month / Day / Year (not to exceed 1 year))

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

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 Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____ (Signature of Person Receiving Medication and Reviewing the Form) _____ (Date)

All students if applicable

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure Medication Administration Authorization Form

Name of Child Care Facility _____

This form authorizes emergency seizure care for _____ ☐ M ☐ F
(Child's Name) (Date of Birth)

while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician _____ Phone#_____ # After Hours_____

Significant Medical History: _____

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Seizure Emergency Protocol (Check all that apply and clarify below)

☐ Call 911 for transport to _____ ☐ Notify parent or emergency contact

☐ Notify treating physician _____ ☐ Other_____

☐ Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure? ☐ **Yes** ☐ **No** If YES, describe process for returning the child to the classroom. _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

_____

Physician Signature: _____ **Date:** _____

Parent Information & Authorization: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

Parent/Guardian Signature: _____ **Date:** _____

All students if applicable

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) **Call 911** (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

All students if applicable

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

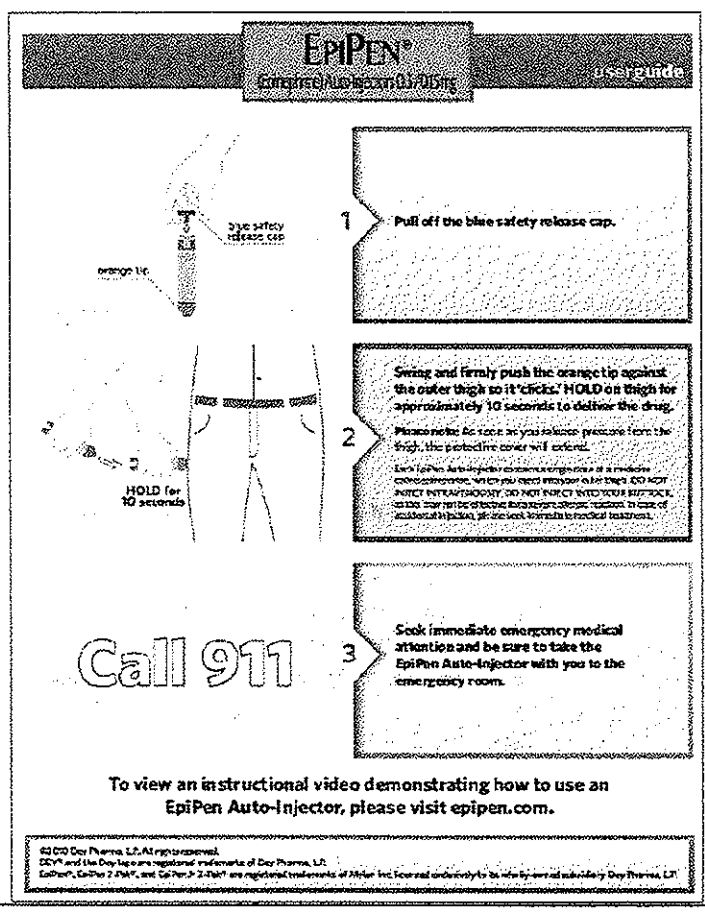
CHILD'S NAME: _____ **Date of Birth:** _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

All Students if applicable

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)

Maryland State Department of Education — Preparing World Class Students

Triggers (list)

_____
_____
_____
_____
_____
_____

Student's

Name:_____ DOB:_____ PEAK FLOW PERSONAL BEST:_____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE: Long Term Control Medication – use daily at home unless otherwise indicated

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(Rescue Medication)			

☐ Prior to exercise/sports/ physical education

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications – to be added to Green zone medications for symptoms

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

☐ Peak flow between _____ and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications – Albuterol and other

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

(School-age children) ☐Yes ☐No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____

3/20/2014