Pre-Kindergarten and Kindergarten Registration for SY 2022-2023

Worcester County Public Schools

(PLEASE PRINT)

1. STUDENT INFORMATION

Child's last name: First: Middle:	☐ Male ☐ Female ☐ Non-Binary	Birth date: • Must be 3 years old by 9/1/22 (PK3) • Must be 4 years old by 9/1/22 (PK4) • Must be 5 years old by 9/1/22 (K) __ __/__ __/__ __ __ __

2. HOUSEHOLD MEMBERS AND MONTHLY INCOME- INFORMATION REQUIRED FOR PRE K REGISTRATION/ OPTIONAL FOR K REGISTRATION

Name of Household Members (Include the child named above)	Monthly Earnings from Work (before deductions)		Monthly Welfare Payments, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Any Other Monthly Income (SSI Benefits)	Check if no income	Social Security Number only if income is reported
	Job 1	Job 2					
1. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
2. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
3. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
4. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
5. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
6. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______
7. ______	$ ______	$ ______	$ ______	$ ______	$ ______	____	______

We are homeless or living in a shelter. ☐Yes ☐No	
☐ Check block if Foster Child. Indicate the child's monthly personal use income. If the child has no personal use income, write "0".	**AMOUMT** **$**

3. **List the child's FOOD STAMP __________ or Temporary Cash Assistance (TCA) case number __________ if applicable.**

4. HOUSEHOLD INCOME INFORMATION – Maryland Senate Bill 856 requires that family income be used to identify students for Priority 1 placement into public prekindergarten.

Household income MUST be documented by submitting one of the following for EACH parent:

☐ 2019 Federal Tax Form ☐Unemployment Verification ☐Active Temporary Cash Assistance Verification
☐ Active Food Stamp Verification ☐ Three (3) current paystubs from employer ☐ Foster Care Proof of Income

Father/Male Guardian Name: ______________________ Employer's Name: ______________________ Employer's Phone #: ______________________	Mother/Female Guardian Name: ______________________ Employer's Name: ______________________ Employer's Phone #: ______________________

5. SPECIAL EDUCATION/IEP INFORMATION

Does your child have an ACTIVE IEP (Individualized Education Plan)? **(Note: Parent must report current IEPs)**

☐ Yes ☐ No

Services Provided by IEP:

☐ Speech ☐ Hearing ☐ Vision ☐ Language ☐ Physical Disabilities ☐ Other:

OVER➡➡➡➡

6. PLEASE CHECK ANY (DOCUMENTED) EMERGENCY, HEALTH SITUATION, OR HOME AND FAMILY CIRCUMSTANCES THAT APPLIES TO YOU OR YOUR CHILD

- ❑ Language Other than English is the primary language spoken at home.
- ❑ elderly parent or a guardian
- ❑ birth weight less than 6 pounds or premature
- ❑ serious injury/trauma (child)
- ❑ single parent (separation, divorce)
- ❑ adolescent parent completing high school
- ❑ disability of parent or siblings
- ❑ parent with emotional/mental health problems
- ❑ child of parent(s) incarcerated
- ❑ abuse and neglect of child
- ❑ death of parent
- ❑ drug/alcohol problem of a parent/guardian
- ❑ parent(s) did not complete high school
- ❑ child exposed to lead
- ❑ long-term illness or use of medication by child
- ❑ chronic illness of parent/guardian

7. TOILET TRAINING

The teacher/assistant and/or nurse are not responsible for helping children in the bathroom.

Is your child self-sufficient in the use of the bathroom (i.e. toilet trained and does not use pull-ups)? ☐Yes ☐No

If No, would you like additional information on toilet training? ☐Yes ☐No

Parent/Guardian Signature:

8a. PRIOR CARE- PARENT RESPONSE

In the last year, has your child been cared for OUTSIDE OF YOUR HOME during daytime hours?	☐Yes ☐No
If you answered Yes to the previous question, where was that care? Please list the name of the childcare facility or provider.	Morning- Afternoon- All Day-

8b. PRIOR CARE- SCHOOL COUNSELOR (Parents DO NOT Complete this Section)

Prior Care	Full Day	Half Day Morning	Half Day Afternoon
Informal Care			
Head Start- Berlin, Stockton, Snow Hill or Other			
Pre-K (List School)			
Child Care Center			
Family Child Care Center			
Non-Public Nursery School			
Kindergarten			

OVER➡➡➡➡

9. ADDITIONAL INFORMATION	
Does your child have a nickname?	
Does your child have any special interests or abilities?	
Are there religious preferences the classroom teacher should know?	
Has your child received counseling or therapy that would be helpful for the school to know?	
Is there any other information that may help us better know your child, such as allergies, special fears or anxieties, medical concerns, custody issues, etc.?	

10. PARENT/GUARDIAN ACKNOWLEDGEMENT/SIGNATURE – PLEASE READ BEFORE SIGNING

CERTIFICATION:

☐ I understand that this information is needed for the receipt of federal funds; that school official may verify the information on the application; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

PRE K Only:

☐ I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT AND THAT ALL INCOME REPORTED IS ACCURATE. I HAVE ONE FORM OF PROOF OF INCOME WITH THIS APPLICATION FOR **EACH PARENT/GUARDIAN.**

☐ I UNDERSTAND THAT THIS INFORMATION IS BEING PROVIDED FOR CONSIDERATION FOR MY CHILD'S PLACEMENT IN THE PRE-KINDERGARTEN PROGRAM AND SCHOOL OFFICIALS MAY VERIFY THE INFORMATION ON THIS FORM AT ANY TIME. I UNDERSTAND THAT IF ANY OF THE INFORMATION IS INACCURATE, MY CHILD'S PLACEMENT IN THE PROGRAM MAY BE JEOPARDIZED.

Printed Name of Parent/Guardian:	**Parent/Guardian Social Security #**

Signature Parent/Guardian (*Application not valid if not signed and dated by parent/guardian*)

Date ____________________

Verification: Your eligibility may be checked at any time during the school year. School officials may ask you to send verification which shows that your child is eligible to participate in the prekindergarten program.

Confidentiality: Financial information included on this form will remain **confidential**. School officials use this information to determine eligibility. The name and eligibility of your child may be given to local officials for evaluation purposes and may be used for reporting to state officials administering and funding the program.

Worcester County Public Schools
Emergency Information/Registration Card

22-23

Today's Date: ______________

PLEASE COMPLETE THE FOLLOWING VITAL INFORMATION

STUDENT INFORMATION				
Legal Last Name		First Name		Middle Name
Social Security No.	Birthdate	Present Grade	Gender M ☐ F ☐	Home Phone

ETHNIC Category **Are you Hispanic or Latino?** ☐ **Yes** ☐ **No**

RACE Category **Everyone must select at least one race below.**

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White

PRIMARY HOUSEHOLD INFORMATION: Name of person(s) the STUDENT LIVES WITH. If a student lives with legal guardian, court order of custody papers must be presented to the school.

Living with:
☐ Both Parents ☐ Mother only ☐ Father only ☐ Self ☐ Agency
☐ Legal Guardian ☐ Mother/Stepfather ☐ Father/Stepmother ☐ Stepfather/Stepmother ☐ Other (specify)

Mother's/Guardian Last Name	First Name	Employer/Address	Business Phone #	Cell Phone #/Emergency #
Father's/Guardian Last Name	First Name	Employer/Address	Business Phone #	Cell Phone #/Emergency #
Parent/Legal Guardian Street Address			City	Zip
Mailing Address (if different from above)			City	Zip

Parent/Guardian email: ______________________________

What is your child's country of birth (if other than USA)? ______________________________
What date did your child first enter the USA? ______________________________

Residence Verification - If your address changes, please provide new documentation. The residence information provided on this form is true and accurate as of this date. I understand that falsification of an address or the use of any other fraudulent means to achieve an enrollment in any Worcester County Public School, will result in immediate revocation of enrollment and other appropriate action being considered.

Signature of Parent/Legal Guardian: ______________________________ Date: ______________

EMERGENCY INFORMATION: List two local persons **(other than yourself)** usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. We attempt to contact parents first.

Name	Relationship to student	Address	Daytime Phone #
Name	Relationship to student	Address	Daytime Phone #

Enter the name of your family physician who may be contacted by school staff members when a parent cannot be reached and medical assistance is indicated.

Family Physician	Address	Phone#

Do you have medical insurance or medical assistance? ☐Y ☐N Medical Assistance #: ______________
Insurance Company: ______________ Insurance #: ______________

Please complete side 2 of the Emergency Card - over

Emergency First Aid Consent

Many times a parent cannot be located immediately, and for this reason we feel that written permission should be available in school files for whatever treatment is needed for the student. If you are in agreement with this policy, please sign the form at the place indicated below.

In the event of serious injury or illness of my child while at school, and I cannot be located for verbal permission, I hereby give the school my written permission to obtain or give emergency medication and treatment.

Date: ____________________ Parent/Legal Guardian's Signature: ______________________________

Transportation Information (please check)

❑ Transported by parent/or/walk: ❑ To school ❑ From school
❑ Transported by school bus

Pick-up address: ______________________________

Address delivered to after school: ______________________________

My child will be attending the following after-school program: ______________________________

Option To Restrict Disclosure Of Student Directory Information

The Family Educational Rights and Privacy Act (Public Law 93-380) authorizes local school systems to disclose certain information from the educational records of a student that is designated as directory information. This designation includes basic biographical information only, **NOT** student grades, test results, or any part of academic or discipline records. You have the right to restrict the school system from releasing any category of directory information about your child by indicating below. Please be aware that if you elect to restrict the release of directory information about your child, information about that child cannot be included in school publications, honor roll or other recognition lists, graduation programs, theatre programs or sports rosters or similar items.

Note: There are other provisions, in law, which allow school systems to release information about students without parental permission under limited circumstances.

❑ Please **ONLY** check this box if you wish to restrict the disclosure of student directory information.

Is your child a foster child? ❑ Yes ❑ No

Is either parent or guardian assigned to active military duty? ❑ Yes ❑ No

For Junior and Senior High School Students Only

Dear Juniors, Seniors and Parents/Guardians:

As part of the "No Child Left Behind Act," the branches of the military service by law may request the names, addresses and phone numbers of juniors and seniors in order to contact the students directly to provide information on programs available in the military. If you **DO NOT** wish to have your child's name included in this list, please fill out the section below and return it to your child's school.

If you do not return this form, your child's directory information will be released to all branches of the military service.

❑ **I DO NOT** want the name, address and phone number of ______________________________, released to the military services.
Print name of student

____
Parent Signature

Rev. 1/17

WORCESTER COUNTY PUBLIC SCHOOLS

22-23

TRANSPORTATION CARD

Child's Name: ______________________________ Grade: ______

Parent(s) Name: ______________________________

____

Emergency Contact Information

Name	Relationship to Student	Phone Number

AM My child will: ❑ Walk to School ❑ Arrive by Car ❑ Ride the Bus

PM My child will: ❑ Walk Home ❑ Be Picked Up ❑ Ride the Bus

Bus pick-up address: ______________________________

____

____

Give specific directions to the above address and a description of the house:

____

____

____

Delivered by bus to: ❑ Home ❑ Other - If not home, give address and specific directions:

____

____

____

______________________________ Parent Signature

______________ Date

Bus In: __________ Bus Out: __________

Worcester County Public Schools
School Medication Administration Authorization Form

This order is valid only for the current school year ________, including the summer session.

School: ______________________________

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, 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 must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: ______________________ Date of Birth: __________ Grade: ________

Condition for which medication is being administered: ______________________

Medication Name: ______________________ Dose: ______________ Route: ____________

Time/frequency of administration: ______________________ If PRN, frequency: ____________

If PRN, for what symptoms: ______________________

Relevant side effects: ☐ None expected ☐ Specify: ______________________

Medication shall be administered from: __________ to __________
MM/DD/YY MM/DD/YY

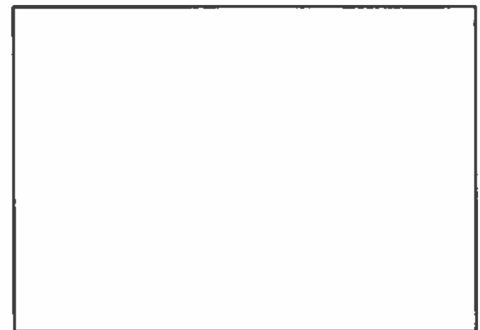
Prescriber's Name/Title: ______________________
(type or print)

Telephone: ______________ Fax: ______________

Address: ______________________

____

Prescriber's Signature: ______________________ Date: __________
(Original signature or signature stamp only)



(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN: ______________________ for the above medication on __________.
Name Date

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the mediation as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: ______________________ Date: __________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: ______________________
Signature Date

School RN approval for self carry/self administration of emergency medication: ______________________
Signature Date

Order reviewed by the school RN: ______________________
Signature Date

Medication for Students While in School

The administration of medication to students in Worcester County Public Schools is a service offered to promote wellness and decrease absenteeism. When there is a need for this service, safe and proper administration is essential. According to state law, therefore, school personnel, including school nurses, may not administer any medication without written doctor's orders. This includes over the counter medications. Whenever possible, medication should be taken by students before coming to school or upon returning home. When this is not possible, school personnel may administer medication to students according to the following guidelines:

A. Before giving any medication, it is necessary that the school have complete written instructions on an appropriate form (HS/Form 1) from the prescribing physician. This form should also include the parent/guardian signature. Instructions shall include date of order, identification of drug by name, dose, time and circumstances of administration, length of time medication is to be continued, and possible side effects. If the physician prefers to use his/her own form, it will be acceptable if he/she writes complete instructions. These instructions must be easily accessible to those responsible for administering the medications as well as those who observe and work with the child.

B. All medication shall be clearly labeled with the student's name, time, and amount of medication to be taken. School nurses or trained school personnel are responsible for observing while the student takes the medication to assure that it is done in accordance with the physician's written instructions and the medicine label.

C. The original prescription container shall accompany all medications to be administered in school. Parents/guardian should request two containers (one for school and one for home) from the pharmacist when getting the prescription filled. Medications should be brought to school by the parent or responsible adult.

D. Medication shall be kept locked in the health suite. There are some children with serious allergies for whom it is necessary to keep an antidote at school. In such cases, this medication should be kept locked, be readily accessible in case of an emergency which requires immediate use.

E. When a physician determines that injection of medication may be necessary as a life saving measure, the school nurse will administer the prescribed medication. In the event that the school nurse is not immediately available, prearranged locally available medical personnel shall be immediately contacted for assistance.

F. The parent/guardian should give the first dose of any new prescription or over-the counter medications, except for prn emergency medications.

G. All medications must be destroyed one week after the expiration date. If not retrieved by a parent or responsible adult, unused medication will be disposed of at the end of the school year.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ________/________/________

COUNTY ____________________ SCHOOL ____________________ GRADE ______

PARENT OR GUARDIAN NAME ____________________ PHONE NO. ____________________

ADDRESS ____________________ CITY ____________________ ZIP ________

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									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 Department of Health and Mental Hygiene Blood Lead Testing Certificate

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME ______________________ / ______________________ / ______________________
LAST FIRST MIDDLE

CHILD'S ADDRESS ______________________ / ______________ / ______________ / __________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ☐Male ☐Female BIRTHDATE ____/____/____ PHONE ______________

PARENT OR GUARDIAN ______________________ / ______________________ / ______________________
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ☐ YES ☐ NO
Has this child ever lived in one of the areas listed on the back of this form? ☐ YES ☐ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ☐ YES ☐ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): ______________ **Signature**: ______________ **Date**: __________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ☐Health Care Provider/Designee OR ☐School Health Professional/Designee

Provider Name: ______________________ Signature: ______________________

Date: ______________________ Phone: ______________________

Office Address: ____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.
Parent or Guardian Name (Print): ______________ Signature: ______________ Date: __________

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ☐ YES ☐ NO

Provider Name: ______________________ Signature: ______________________

Date: ______________________ Phone: ______________________

Office Address: ____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

WORCESTER COUNTY PUBLIC SCHOOLS

Pupil Services

6270 Worcester Highway, Newark, MD 21841

HIPAA- Compliant Authorization for Exchange and Release of Health and Education Information & Immunizations

Patient/Student's Name: ______________________________ DOB: ____________________

I hereby authorize ____

____

(insert health care provider name, title, address and phone number)

and ____

____

(insert name and title of school official, address and phone number)

to exchange my/my child's health and education information/records for the purpose listed below.

Description:

The information to be disclosed consists of:

The education information to be disclosed consists of:

Purpose: This information will be used for the following purpose(s):

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Immunizations
5. Other: ______________________________________

Authorization

This authorization is valid for one calendar year. It will expire on ____________________(insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

______________________________ ____________________

Parent Signature Date

____

Name Printed, Address and Phone #

______________________________ ____________________

Student's Signature * Date

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maryland, a competent minor, depending on age, can consent to outpatient mental health care, drug and alcohol abuse, testing for HIV/AIDS, and reproductive health care services.

Copies: Parent or student*

Physician or other health care provider releasing the protected health information

School official requesting/receiving the protected health information

Rev. 7/13

Worcester County Public Schools
HOME LANGUAGE SURVEY

Student Name: ______________________ Birth Date: ______________ ❑ M ❑ F

Parent/Guardian Name: ______________________________________

Address: ______________________________________

Home Telephone: ______________________ Work Telephone: ______________

School: ______________ Grade: __________ Date: ______________

In accordance with federal and state requirements, the Home Language Survey will be administered to all students and used only for determining whether a student needs English language support services and will not be used for immigration matters or reported to immigration authorities.

If a language other than English is indicated on two or more of the three questions below, the student will be assessed for English language support services. Additional criteria for testing may be considered.

1. What language(s) did the student first learn to speak?______________________
2. What language does the student use most often to communicate?______________
3. What language(s) are spoken in your home?______________________________

If a language other than English was indicated on two or more of the questions above, please complete the following four questions.

4. In what country was your child born?______________________
5. Has your child attended any school in the US? ❑ Yes ❑ No

   If yes, name of school:______________________ State: ______ Date:__________
6. Is your child able to read and write in their home language? ❑ Yes ❑ No
7. Please describe the language understood by your child, (Check only one)

   ❑ Understands only the home language and no English.

   ❑ Understands the home language and English equally.

   ❑ Understands only English.

If a language other than English is indicated on two or more of the first three (1-3) questions, please forward one copy to the ESOL/instructor in your building and one copy to Angela R. Paris at the Central Office.

OFFICE USE ONLY			
Date Received	**Date Assessed**	**Qualifies for ESOL Services** ❑ Yes ❑ No	**ESOL Instructor**

Rev. 5/17

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

MARYLAND Department of Health and Mental Hygiene

Maryland Schools Record of Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** *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.* (http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** *A Maryland Immunization Certification form for newly enrolling students 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 school. This form can be found at:* *https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20Immunization%20Certification%20Form%20(DHMH%20896%20-%20February%202014).pdf.*

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** *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:* *https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Lead/MarylandDHMHBloodLeadTestingCertificateDHMH4620_revised3.24.2016c.pdf.*

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

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 in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf. **If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene　　Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

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

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?

No Yes Name(s) of Medications: ________

No Yes Treatment ___________________, etc.)

Does your child require any special procedures? (catheteriz

No Yes

Parent/Guardian Signature ___________________________ation, etc.)

Date:______________________

PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes ______________________________

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes ______________________________

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No Yes ______________________________
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ______________________________

7. **Screenings**	**Results**	**Date Taken**
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

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

(Child's Name)____has had a complete physical examination and has:

no evident problem that may affect learning or full school participation   problems noted above

____

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date