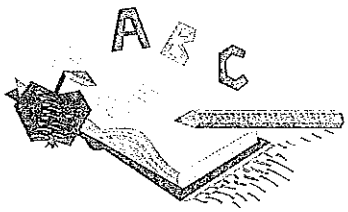


All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

Enrollment Checklist

___ Health Inventory Part 1 (completed by parent)
___ Health Inventory Part 2 (completed/signed by doctor)
___ Immunization Records
___ Lead Screening (completed at age 1 and 2)
___ Emergency Card
___ Parent Handbook form
___ Enrollment Agreement
___ Photo/Video Waiver
___ IEP form (if needed)
___ Food Program application

AACLC School Closing Days

2022

Memorial Day	May 30
Independence Day	July 4
School Prep Days	August 25 ,26
Labor Day	September 5
Thanksgiving	November 24,25
Christmas	December 23, 26
New Years Eve	Dec 30 Close at 3

2023

New Years Day	January 2
Good Friday	April 7
Memorial Day	May 29
Independence Day	July 4
School Prep Days	August 24 ,25
Labor Day	September 4
Thanksgiving	November 23,24
Christmas	December 25, 26
New Years Eve/Day	January 1

Enrollment Supplies

Infant Rooms

- Diapers and wipes (a case/time for FT and sleeve/time for part time is ok)
- 3 sets of weather appropriate clothing. Bibs, if needed. Shoe size bin w/lid.
- 2 crib sheets
- Bottles for every feeding (pre-made, pre-powdered, or pre-watered. NO GLASS. Must be fresh bottle for every feeding) If breast feeding, only enough for the day please.
- Pacifier, if needed.
- Drawstring/reusable bag on Mondays and Fridays

Toddler Room

- Diapers and wipes(a case/time for FT and sleeve/time for part time is ok)
- 3 sets of weather appropriate clothing and shoes in shoe size bin w/ lid
- 2 crib sheets
- 2 Sippy cups per day

Twos, Threes, and Fours

- Cot supplies- cot sheet, blanket, pillow (optional)
- Drawstring/reusable bag to keep cot supplies together
- 2 sets of weather appropriate clothing and shoes in shoe size bin w/ lid
- 1 box of tissues
- Diapers/ Pullups and wipes, if not toilet trained
- Reusable water cup/bottle

Threes and Fours only: Plastic pencil box, pencils, pack of 6/8 crayons, scissors, glue bottle or stick

Medication forms are needed for ALL medications. These forms are available in the office if needed. A Doctor does not need to sign a form for diaper cream unless treating a rash or for sunscreen. If there are any allergies or asthma issues, please inform teachers. There are additional forms needed for children with these conditions.

PLEASE LABEL EVERYTHING!!!

Items needed for the 3's and 4's class

*Plastic pencil box

*box of 8 crayons

*box of 12 colored pencils

*Plastic pocket folder

*dull point scissors

*pack of 4 glue sticks

*small pack of dry erase markers

*pack of chubby pencils

Thanks! Ms. Crystal and Ms. Mautrice

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☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

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

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	Name:	Physical Exam:
Address:	Address:	Dental Care:
Phone #	Phone	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.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

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

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

_____ _____
Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

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

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

☐ No ☐ Yes, describe:

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

☐ No ☐ Yes, describe:

3. PE Findings

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

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_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 %tile				
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ 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:

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: _____

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

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.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1													
2													
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4													
5													

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

Clinic / Office Name
Office Address/ Phone Number

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.

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: _____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:___ No:____

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

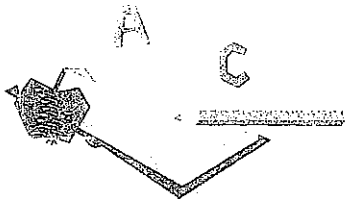
Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

OCC 1214 (Revised 01/2022) - All *previous editions are obsolete.*



All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

I/We, _____, parent/legal guardian of _____ acknowledge we have viewed a copy of All About Children Learning Center's parent handbook as posted on the company's website. (arbutuspreschool.com) and agree to all the terms provided within the handbook. I/We understand the polices described are not conditions of enrollment and does not create a contract for care. AACLC reserves the right to alter, amend, or modify guidelines with written notice given to parents in advance.

_____ _____

Signature Signature

_____ _____

Printed name Printed name

Individualized Infant Care Plan

Child's Name: _____ DOB/Age: _____

Enrollment Date: _____ Days & Hours of Attendance: _____

Allergies/Medical Conditions: _____

Breast Milk or Formula- Brand of Formula: _____

Heated by: _____

Eating Schedule/Preferences:

_____

_____

Napping Schedule/Preferences:

_____

_____

Diapering Preferences:

_____

Activity Schedule (Includes twice daily outside time):

_____

_____

Likes/Dislikes:

_____

Special Needs/Instructions:

_____

Primary Staff Member Name Printed: Signature and Date:

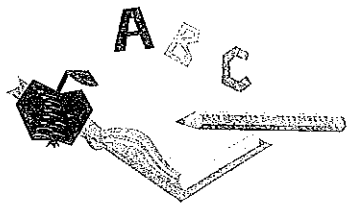
_____

_____

Parent(s) Name Printed: Signature(s) and Date:

_____

_____



All About Children Learning Center
1201 Maple Ave
Arbutus, MD 21227
410-242-6009

Cot Permission Form

I, _____, give permission for my child, _____ who is under two, to sleep on a cot at All About Children Learning Center. I will provide the appropriate bedding for my child. Children under 1 are not permitted to use pillows.

_____ _____

Parent Signature Date

IEP Information for New Families

AACLC would like the opportunity to help all the children in our care in any way that we can. We offer connections to many programs to help the whole child on different levels. If your child is currently in need of support, we may be able to help. If your child is already in a program and have an IFSP/IEP, please know that we are here to help your family in any way we can. We encourage you to have program providers come to visit your child in our setting and to have our teachers involved as much as they are able. If your child has a current IEP/IFSP please submit to us upon enrollment. Please return this form if any of the following applies to your child:

_____ I would like information for programs for my child

_____ I currently have an IEP/IFSP for my child.

Optional:

- Workers name and contact information_____
- Home School Location _____
- Weekly visit dates and times_____

We would like to work as a team in any way possible to provide the best care for your child. Submitting any information regarding your child's IEP/IFSP is completely optional, but helps us to provide proper accommodations, if necessary. Thank you in advance and we look forward to serving your family.

Heather Kuchta

Director of AACLC

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed or approved private homes.
- **After School Care Programs**: Centers in low-income areas provide free snacks to School-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

AACLC
1201 Maple Ave.
Arbutus, MD 21227

Nondiscrimination

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program

Center Name: All About Children Learning Center

Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/ or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period . Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP requlations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child (ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours									
BIRTH DATE	Other:									
AGE	**Enrollment Date:** **Withdrawal Date:**									

Signature

Signature of Parent or Guardian _____ *Date* _____ *Telephone Number of Parent or Guardian* _____

CHILD CARE REPRESENTATIVE USE ONLY: _____ *Name of Representative/Signature* _____ *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) ***mail: U.S. Department of Agriculture***
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) ***fax: (202) 690-7442; or***

(3) ***email: program.intake@usda.gov***

This institution is an equal opportunity provider.

The Planning Council & MSDE Form

INFANT FEEDING PLAN (For children 0 - 12 mos.)

Center Name: All About Children Learning Center

Address: 1201 Maple Avenue

Dear Parent(s)/Legal Guardian(s):

This center/provider offers Standard iron-fortified infant formula

Formula name

for all enrolled infants at no additional charge. It is your option whether or not to use this formula based on your preference and your infant's needs. All formula that is provided to infants at this facility must be iron-fortified as required by the Child and Adult Care Food Program.

PARENT FORMULA REQUEST

Please check one of the following options, **regarding FORMULA:**

_____I will provide expressed breast milk for my infant. I understand that the breast milk I supply must be labeled with my child's name and the date the milk was expressed.

_____I will use the infant formula offered by this facility.

_____I ***will not*** use the infant formula offered by the facility. I will supply the following Infant formula for my infant _____.

Formula name

I understand that I must supply sufficient infant formula each day to meet my child's needs. Bottles must be labeled with my child's name and be dated. Bottles must be taken home daily.

PARENT FOOD REQUEST

When your infant is developmentally ready to eat solid foods, do you accept or decline the provider/facility-supplied food?

Please check one of the following options, **regarding FOODS:**

_____I will supply all supplemental foods for my infant. [*Center may not claim my child for meals*]

_____I will **ACCEPT** the supplemental foods offered to my infant(s) by this facility.

Child's Name: _____

Child's Date of Birth: _____

_____ _____

Signature of Parent/Legal Guardian Date

All food and beverages served to infants in this facility must be in compliance with the infant meal pattern required by the Child and Adult Care Food Program.

Meal Benefit Application for Child Care Centers

July 01, 2022 - June 30, 2023

For more information, read **Instructions for Completing** or call: (855) 427-2888

Step 1 **List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).**

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 **Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? Circle One: Yes No**

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number:

Step 3 **Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)**

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults):

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member:

Check if No SSN:

Step 4 **Contact Information and Adult Signature**

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name: Signature:

Street Address:

Date: Phone #:

Step 5 **OPTIONAL: Children's Racial and Ethnic Identities**

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

- Hispanic or Latino
- Not Hispanic or Latino

Race (Check one or more):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $

Weekly | Every 2 Weeks | Twice a Month | Monthly | Yearly

Eligibility: Free | Categorically Eligible | Reduced | Paid

Determining Official's Signature: Date:

Date Withdrawn:

Center Name: All About Children Learning Center

INSTRUCTIONS FOR COMPLETING MEAL BENEFIT APPLICATION - Child Care Center

Complete the application using the instructions below. Sign the form and return it to the center. If you need help, call (855) 427-2888

STEP 1 - CHILDREN'S INFORMATION - ALL HOUSEHOLDS COMPLETE

List the first and last name of all enrolled children. Indicate if a foster child, homeless, migrant, runaway, or in Head Start, Early Head Start or Even Start by checking the box. If **ALL** children listed are foster, homeless, migrant, runaway, or in Head Start, Early Head Start, or Even Start, skip to Step 4.

STEP 2 - CASE NUMBER

If any member of your household receives benefits from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA), write the case number and skip to Step 4.

STEP 3 - NAMES OF ALL HOUSEHOLD MEMBERS AND GROSS INCOME

- List the first and last name of everyone in your household, whether they receive income or not. Your household includes all those living as one economic unit. Include yourself, all children living with you, including foster children and any other person living in your household, related or not. List each type of income received last month and how often it is received. You must indicate how much in whole dollars, and how often received (weekly, bi-weekly, twice a month, monthly, yearly). **If a household member has no income-write '0' in the income box.**
- Report all income as gross income. Gross income is the amount earned before taxes and other deductions. This is not the same as take- home pay. Gross income includes unemployment benefits, Worker's Compensation, Supplemental Security Income and Veteran's benefits, Social Security, private pensions or disability, strike benefits, income from trusts or estates, annuities, investment income earned interest, rental income and regular cash payments from outside household. For self-owned business, farm, or rental income, report income as **net income**.
- If you are in the Military Housing Privatization Initiative, do not include your housing allowance as income. Do not include combat pay.
- Indicate the total number of household members in the space provided.
  - The form must have the last four digits of the Social Security Number of the primary wage earner or adult who signs unless the adult does not have a Social Security Number. If the adult does not have a Social Security Number, check the box. The last four digits of the Social Security Number are not needed if you listed a FSP or TCA case number, or if you are only applying for foster children.

STEP 4 - SIGNATURE - ALL HOUSEHOLDS COMPLETE

All forms must have the signature of an adult household member.

STEP 5 - RACIAL/ETHNIC IDENTITY

You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.

Federal Income Guidelines

Household Size	Year	Month	Week
1	$25,142	$2,096	$484
2	33,874	2,823	652
3	42,606	3,551	820
4	51,338	4,279	988
5	60,070	5,006	1,156
6	68,802	5,734	1,324
7	77,534	6,462	1,492
8	86,266	7,189	1,659
For each additional family member add	$8,732	$728	$168

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you are only applying for foster children, or you list a Food Supplement Program or Temporary Cash Assistance case number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine

All About Children Learning Center
1201 Maple Ave
Baltimore, MD 21227
410-242-6009

Tuition Cost for Enrollment

I, _____, enroll my child _____

for full/ part time care: Monday Tuesday Wednesday Thursday Friday. (please circle days). We plan to attend from the hours of _____ to _____. The fee for this weekly tuition will be $_____ per week paid on Fridays the week before care is provided. I agree to give 2 weeks notification if/when I decide to leave AACLC. I understand if I do not give proper notification I can be charged up to 2 weeks tuition. I also understand that all holidays, sick days, closings and any other days must still be paid with tuition. After one year of enrollment I may receive one week half priced tuition for vacation, all 5 days in one week.

_____ _____

Parent Signature Date

_____

Director Signature

Release and Consent Form
For the use of recorded materials, image, sound, videotape, film, photograph, CD, or audiotape.

I hereby authorize All About Children Learning Center and its affiliates, employees and assigns to use the subject's name, voice, likeness and/or picture (still or motion) for use in advertising, promotion, reproduction, or broadcast of said project. Furthermore, I hereby release All About Children Learning Center and its affiliates, employees and assigns from all liabilities in connection with the use of the aforementioned project materials.

I agree that, All About Children Learning Center, and any designates shall have the right to use the Film/Video/Print/Audio/Media produced hereunder at any time, as frequently as desired and in any place.

I acknowledge that I am over the age of eighteen and authorize All About Children Learning Center and its designates to use in any manner whatsoever and without restriction any recorded Film/Video/Print/Audio/Media of the subject or property belonging to the subject, any statements or recordings of the subject's voice made by the subject, or any use of the subject's name during the process for any purpose and without restriction.

Project Title: All About Children Learning Center Web Site

Name of Subject /Minor_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email_____

I, _____ as the Subject, or Father, Mother, or Guardian of the Minor named

_____as "subject," do consent to the release of the material described above.

Signature_____

Print Name_____ Relationship to Subject_____