

# 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.

When parents 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 \_\_\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

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

Mother's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Mother's Employer/School \_\_\_\_\_  
Name Address

Mother's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Last First

Father's Employer/School \_\_\_\_\_  
Name Address

Father's Home Address (If different from above) \_\_\_\_\_  
Street/Apt.# City State Zip Code

Work Telephone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Name of Person Authorized to Pick Up Child (daily) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

**ANNUAL UPDATES** \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

**INSTRUCTIONS TO PARENT:**

- (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: \_\_\_\_\_

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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

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

**MEDICATION ORDER FORM**

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions. Prior written permission from the child's parent is a requirement. If possible, arrange the time of dosage so the child receives the medication at home. Fill out a separate form for each prescription or non-prescription drug.

**PRESCRIPTION MEDICATIONS:** Prescription medications must be in a container labeled by the pharmacy or physician with the child's name and expiration date. The child may receive medication only according to the written instructions of the health practitioner or the medication label, as show below.

**NON-PRESCRIPTION MEDICATIONS:** A child may receive only one dose per illness, except acetaminophen (Tylenol) and topical medication. A licensed health practitioner must approve the medication and dosage for the child to receive more than one dose.

Name of Child: \_\_\_\_\_

This medication is being given for the following condition(s): \_\_\_\_\_

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
ADDITIONAL INSTRUCTIONS (including instructions not given on the prescription):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				

I/We authorize \_\_\_\_\_ to administer the above named medication to my/our child.  
Name of Child Care Provider or Facility

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

COMPLETE ONLY IF MORE THAN ONE DOSE OF NON-PRESCRIPTION MEDICATION IS TO BE GIVEN	
Instructions for more than one dose of a <u>non-prescription medication</u> :	
Note any side effects of this medication:	
Note any reasons or conditons when this medication should be stopped or not given:	
Signature of Health Practitioner:	Date:
Stamp, Print or Type Name of Health Practitioner	Phone Number
If the above section is not signed by the health practitioner, the health practitioner/designee must give oral permission to the provider directly, and the provider must complete the following:	
Name of Practitioner or designee giving approval:	
Signature of person receiving approval from health practitioner:	Date:
	Time:



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**HEALTH INVENTORY - ADDENDUM**

**CHILD'S PERSONAL RECORD FOR  
CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND  
NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS**

Under Maryland law, a child under six years of age who is admitted to child care must have appropriate screening for lead poisoning. Parent(s) or guardian(s) must submit evidence of this screening to the child care provider within 30 days of admission to care. Under Maryland law, children who reside (or have ever resided) in certain areas of the State designated as at-risk for childhood lead poisoning must receive one or more blood lead tests. The at-risk areas requiring blood lead testing (per list revised May 2004 by DHMH), and instructions for that testing, are specified on the back of this form.

*To be completed by a HEALTH PRACTITIONER:*

\_\_\_\_\_  
Child's Name  
\_\_\_\_\_  
Child's Birth Date  
has received appropriate lead screening and/or blood lead testing.

**NOTE** - If this child resides, or has ever resided, in an area listed on the back of this form, provide the following information about the child's blood lead testing: Test #1 \_\_\_\_\_ Date \_\_\_\_\_ Test #2 \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Practitioner  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Address  
\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City/Town  
\_\_\_\_\_  
State  
\_\_\_\_\_  
Zip Code

*To be completed by the child's PARENT/GUARDIAN:*

\_\_\_\_\_  
Name of Child's Parent or Guardian  
\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/Town  
\_\_\_\_\_  
State  
\_\_\_\_\_  
Zip Code

\* \* \* \* \*

**PLEASE RETURN THIS COMPLETED FORM TO:**

Name of: \_\_\_\_\_  
(Child Care Center, Family Child Care Home, School)

Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City/Town  
\_\_\_\_\_  
State  
\_\_\_\_\_  
Zip Code

TO THE ATTENTION OF: \_\_\_\_\_

## At Risk Areas by Zip Code and Blood Lead Testing Instructions

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1<sup>st</sup> test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1<sup>st</sup> and 2<sup>nd</sup> tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1<sup>st</sup> test is done after 24 months of age, one test is required. The child's health care provider should record the test dates on this form and certify them by signing or stamping the signature section of the form. All forms should be kept on file with the child's health records.

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

\* Maryland State Department of Education, Office of Child Care Health Inventory Lead Addendum (OCC 1215-A)

\* Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (DHMH 4620, rev. May 2004)

Both available in PDF format <http://www.fha.state.md.us/och/html/lead.html>

**For more information on blood lead testing, contact your Local Health Department**