

27108 Mt. Zion Church Road Mechanicsville, MD 20659 Office Hours—Monday—Thursday 9a.m. to 3p.m. Preschool Office—301-884-5455 Church Office—301-884-4132 Email—Preschool-mtzion@md.metrocast.net or mtzpreschool@gmail.com Website—Mtzionpreschool.com Facebook—Mt. Zion United Methodist Church Preschool

Registration Packet

Dear Parent/Guardian(s),

Thank you for your interest in joining us at Mt. Zion UMC Preschool. The following forms and fees should be returned to the preschool by Aug. 1st in order to officially enroll your child(ren) into our program:

- □ Registration Form
- Enrollment Contract
- Emergency Form
- Health Inventory Form with Immuniztion Record and Lead Testing Certificate

(a portion of this form must be completed by your pediatrician)

- \Box The non-refundable registration fee is due at registration.
- The class activity fee and first month's tuition are due by Aug. 1st to ensure your child(ren)'s placement into our program.

Family Registration



Child Information

Registration Date ____

1st Child									
Last Name			First Name			ML	Nickname		
Entering grade	[]Male []Female	Sirth	Date	Birth City/5t	ate		NO.	Social Security #	
	[] Prefer not to specify			City			State:		
Existing medical con	ditions, medications and/or special	attention	n your child may requir	e					
Allergies									
Pediatrician's Name			Phone		Address				
Photos: May we take [] Yes [] No	e and maintain a photo of your chil	d for secu	nity purposes?						
2nd Child									
Last Name			First Name			ML	Nickname		
Entering grade	[] Male [] Female [] Prefer not to specify	Sirth	Date		Birth City/State		State:	Social Security #	
Existing medical con	Existing medical conditions, medications and/or special attention your child n								
Allergies									
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Pediatrician's Name			Phone	ne Address					
Photos: May we take []Yes []No	r and maintain a photo of your chil	d for secu	rity purposes?						
3rd Child									
Last Name			First Name	First Name		ML.	Nickname		
Entering grade	[] Male [] Female [] Prefer not to specify	Birth	Date	Birth City/St	ate			Social Security #	
Existing medical con	ditions, medications and/or special	attention	o your child may requir	City: e			State:		
Allergies									
Pediatrician's Name			Phone		Address				
CONDUCTORS (9040);			E OVICE		Address				
Photos: May we tak []Yes []No	e and maintain a photo of your chil	d for secu	rity purposes?						
Additional Com	ments & Information:								

Primary Guardian Information Name(s) of person(s) with whom child is living

1st Primary Guardian								
Last Name:	Last Name: First I			First Name			Relationship to Child	
Email Address			Work Phone	2			Cell Phone	
Occupation	Employee			Work Address				Work Hours
2nd Primary Guardian								
Last Name		First N	irst Name			ML	Relationship to Child	
Email Address		-	Work Phone				Cell Phone	
Occupation	Employee			Work Address				Work Hours
Which Guardian Should be C	Which Guardian Should be Called First?. Hom			2			Preferred language for written communication	
Home Resident Street Address				Apt #	City		1	Zip Code
Mailing Address (if different than above)			Apt #	City			Zip Code	

Second Guardian Information

Non-primary custodial parent

1st Non-primary Guardian							
Last Name	First I	First Name			Relationship t	o Child	
Email Address		Wark Phone			Cell Phone	Cell Phone	
2nd Non-primary Guardian		<u>k</u>					
Last Name	First	st Nome			Relationship to Child		
mail Address		Work Phone			Cell Phone		
Which Guardian Should be Called First?		Home Phone			Should mailin	gs be sent to this household also? [] Yes [] No	
Second Household Mailing Address		Apt #	City		State	Zip Code	

Additional Comments & Information: __

Emergency Contacts and Authorized Pickups

1st Contact/Pickup				
Last Name		First Name		Relationship to Child
Home Phone	Cell Phone Cell Phone		[] Able to pick up all c [] Not able to pick up	hildren in the family the following children:
2nd Contact/Pickup				
Last Name				Relationship to Child
Home Phone	Cell Phone		[] Able to pick up all c [] Not able to pick up	hildren in the family the following children:
3rd Contact/Pickup				
Last Name First Name		First Name		Relationship to Child
Home Phone	Iome Phone Cell Phone		[] Able to pick up all c [] Not able to pick up	hildren in the family the following children:

Additional Comments and Information

Is there is any other information that would be helpful to our management and teaching staf?

Signature

Parent / Guardian Signature

I.,

Enrollment Contract

Terms and Conditions

, hereby consent to the enrollment of my child, _

into Mt. Zion United Methodist Church Preschool for the _____school year. By signing this contract I agree to and accept the following terms and conditions.

- A non-refundable registration fee of \$50 (\$70 for families) is due at the time of registration.
- The class <u>activity fee</u> and <u>first month's tuition</u> are due August 1.
- <u>Nine tuition payments</u> (Aug April) will be paid at the beginning of each month, unless the yearly tuition has been
 paid in full, or other prior arrangements have been made.
- Tuition payments received after the fifth of each month are subject to a <u>\$10 late fee</u>.
- A fee of <u>\$10 and any bank fees incurred</u> will be charged in the event of a returned check. After a second returned check, all payments must be made in cash, cashier's check, or money order.
- In the event of a withdrawal from the Preschool, a <u>thirty day notice</u> or <u>one month's tuition</u> in lieu thereof, will be required.
- If the monthly payment cannot be made on time, the Preschool Director should be notified immediately.
- If a default in payment owed to Mt. Zion UMC Preschool occurs, a conference may be held and the child may be
 removed from the program. If the account is referred to a collection agency, a fee of up to 25% of the principle
 amount due will be required.

By signing this contract, I agree to pay tuition based on the payment that I have selected. I agree to comply with the above terms and conditions, the school policies as contained in the Parent's Handbook and the Discipline Policy, as well as directives from the Director's office during the enrollment of the above named child. I acknowledge that I have read the Guide to Regulated Child Care (earlychildhood.marylandpublicschools.org).

The following parties acknowledge that this is the entire agreement and that no modification can be made unless made in writing and signed by all signatories to the original contract.

Guardian's Name (Print)	Signature	Date		
Guardian's Name (Print)	Signature	Date		
Name of Account Payce -if not Guar	dian (Print)	Signature	Date	
			Revis	ed 1/19

*Please retain a copy of this contract for your records, and return the original to the Preschool.

Date:

Page 1/2

First

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Address Street/Apt. # City State Zip Code hild's Physician or Source of Health Care	Name	Last	Fire		Teléphone (H		(w)	
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ignature of Parent/GuardianDate	gnature of Pa	ier woueroran						

	IENT OF EDUCATION - Office of Child Care
INSTRUCTIONS TO PARENT/GUARDIAN: (1) Complete the following items, as appropriate, if yo care.	our child has a condition(s) which might require emergency medical
(2) If necessary, have your child's health practitioner indicated.	review the information you provide below and sign and date where
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:	
OTHER SPECIAL MEDICAL PROCEDURES THAT MA	Y BE NEEDED:
COMMENTS:	
Note to Health Practitioner: If you have reviewed the above information, plea	ase complete the following:
Name of Health Practitioner	Date
Signature of Health Practitioner	Telephone Number

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

completed by the p not need a lead tes child born on or at	arent or guar t (children m her January 1.	en enrolling a child in chi dian. BOX B, also compl ast meet all conditions in I , 2015, and any child born sted due to religious object	eted by parent/gu Box B). BOX C before January 1	ardian, is for a chill should be complete , 2015 who does no	d born before Ja ed by the health et meet all the co	nuary 1, 201 care provide	5 who does r for any
BOX A-Parent	/Guardian C	ompletes for Child Enrol	ling in Child Ca	re, Pre-Kindergart	ten, Kindergart	en, or First	Grade
CHILD'S NAME		LAST	//////	FIRST		1.000-001-0	
CHILD'S ADDR		2012/04/01		0.7395.0	1	MIDDLE	
	STREET	ADDRESS (with Apartment	5000002	CITY	STAT	E	ZIP
SEX: Male	Female	BIRTHDATE	1 I.	PHONE			
PARENT OR GUARDIAN		LAST		FIRST		MIDDLE	
Was this child bor Has this child <u>ever</u>	n on or after Ja lived in one o		EVERY question	below is NO):	NOT enrolled	NO	I AND the
		talk with your child's h			Q YES Q	NO	
	If all a	nswers are NO, sign below	and return this fo	rm to the child care	provider or scho	ol.	
Parent or Guardi	ian Name (Prin	nt):	Signature:		Da	te:	
	If the answ	ver to ANY of these questio Box B. Instead, have b				ot sign	
	BOXC	Documentation and Cert	tification of Lea	I Test Results by I	Iealth Care Pro	wider	
Test Date	Type (V	-venous, C=capillary)	Result (mcg/c	L)	Comr	nents	
				-			
Comments:							
Person completing Provider Name:		h Care Provider/Designee	Signature;				
Date:		11	5			-	
Office Address:							
		BOX D	– Bona Fide Re	igious Beliefs			
blood lead testing	of my child.	child identified in Box A,	above. Because	of my bona fide reli	5		- Chi - 10
This part of BOX I	D must be com	pleted by child's health car	e provider: Lead	risk poisoning risk as	ssessment question	maire done: C	YES NO
Provider Name:			Signature				
Date:			Phone:				
			2 ************************************				
Critice Paddress.							
DHMH FORM 462	20 REV	ISED 5/2016 RE	PLACES ALL PREV	IOUS 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	Baltimore Co. (Continued) 21212	Carroll 21155	Frederick (Continued) 21776	Kent 21610	Prince George's (Continued) 20737	Queen Anne* (Continued) 21640
	21215	21757	21778	21620	20738	21644
Anne Arundel	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714 20764	21221 21222	21791	21787 21791	21651 21661	20742 20743	21657 21668
20779 21060	21224 21227	Cecil 21913	21798	21667	20746 20748	21670
21061	21228		Garrett	Montgomery	20752	Somerset
21225 21226	21229 21234	Charles 20640	AUL.	20783 20787	20770 20781	ALL.
21402	21236	20658	Harford	20812	20782	St. Mary's
Baltimore Co.	21237 21239	20662	21001 21010	20815 20816	20783 20784	20606 20626
21027 21052 21071	21244 21250 21251	Dorchester ALL	21034 21040 21078	20818 20838 20842	20785 20787 20788	20628 20674 20687
21082 21085 21095	21282 21286	Erederick 20842 21701	21082 21085 21139	20868 20877 20901	20750 20791 20792	Talbot 21012
21111	Baltimore City	21703	21111	20910	20799	21654
21133 21155	ALL	21704 21716	21160 21161	20912 20913	20912 20913	21657 21665
21161 21204	Calvert 20615	21718 21719	Howard	Prince George's	Queen Anne's	21671 21673
21206 21207	20714	21727 21757	20763	20703 20710	21607 21617	21676
21208	Caroline	21758		20712	21620	Washington
21209 21210	ALL	21762 21769		20722 20731	21623 21628	ALL.
						Wicomico ALL
						Worcester

ALL

Lead Risk Assessment Questionnaire Screening Questions:

- 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?
- 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?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

DHMH FORM 4620 REVISED 5/2016 REPLACE

REPLACES ALL PREVIOUS VERSIONS