Mt. Zion UMC Preschool

procare SOFTWARE®

Mechanicsville Md

301-884-5455 mtzpreschool@gmail.com preschool-mtzion@md.metrocast.net www.mtzionpreschool.com

Child Information

Registration Date: _____

1st Child

Last Name	First Name	M.I.	Nickname

Age Upon Entry	[ ] Male [ ] Female	Birth Date	What class is your child entering? [ ] 2s M/W [ ] 2s T/Th [ ] 3s AM [ ] 3s PM [ ] 4s AM [ ] 4s Full Day

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain photos of your child?

[ ] Yes [ ] No

2nd Child

Last Name	First Name	M.I.	Nickname

Age Upon Entry	[ ] Male [ ] Female	Birth Date	What class is your child entering? [ ] 2s M/W [ ] 2s T/Th [ ] 3s AM [ ] 3s PM [ ] 4s AM [ ] 4s Full Day

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain photos of your child?

[ ] Yes [ ] No

3rd Child

Last Name	First Name	M.I.	Nickname

Age Upon Entry	[ ] Male [ ] Female	Birth Date	What class is your child entering? [ ] 2s M/W [ ] 2s T/Th [ ] 3s AM [ ] 3s PM [ ] 4s AM [ ] 4s Full Day

Existing medical conditions, medications and/or special attention your child may require

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain photos of your child?

[ ] Yes [ ] No

Primary Guardian Information

1st Primary Guardian			
Last Name	First Name	M.I.	Relationship to Child
Email Address	Work Phone		Cell Phone
Occupation	Employer		

2nd Primary Guardian			
Last Name	First Name	M.I.	Relationship to Child
Email Address	Work Phone		Cell Phone
Occupation	Employer		

Which Guardian Should be Called First?	Home Phone		
Home Resident Street Address	Apt #	City	Zip Code
Mailing Address (if different than above)	Apt #	City	Zip Code

Emergency Contacts and Authorized Pickups

1st Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____

2nd Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____

3rd Contact/Pickup		
Last Name	First Name	Relationship to Child
Home Phone	Cell Phone	[ ] Able to pick up all children in the family [ ] Not able to pick up the following children: _____

Additional Comments and Information

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

Signature

Parent / Guardian Signature

Date

Staff use: Last First *Date:* _____

Enrollment Contract

Terms and Conditions

I, _____ , 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 **activity fee** and **first month's tuition** are due August 1.
- **Nine tuition payments** (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 **$10 late fee**.
- A fee of **$10 and any bank fees incurred** 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 **thirty day notice** or **one month's tuition** 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 Payee -if not Guardian (Print)	Signature	Date

Revised 1/19

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

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

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

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

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

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

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

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ____ Date of Birth: ______________________

Medical Condition(s): ____

____

Medications currently being taken by your child: ____

____

Date of your child's last tetanus shot: ____

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ____

____

(2) If signs/symptoms appear, do this: ____

(3) To prevent incidents: ____

____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ____

____

____

____

COMMENTS: ____

____

____

____

____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ Name of Health Practitioner	______________________________ Date
______________________________ Signature of Health Practitioner	(_____)________________________ Telephone Number

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.

COVID-19 PUBLIC HEALTH EMERGENCY ACKNOWLEDGMENT AND DISCLOSURE FOR

MT ZION UMC PRESCHOOL

This form should be reviewed and signed by all parents/guardians and emergency contacts.

Please read and initial each statement below.

1. ____I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the **Mt Zion UMC Preschool** facility beyond the designated drop-off and pickup area located at 27108 Mt Zion Church Rd Mechanicsville MD 20659. I understand that this procedure change is for the safety of all persons present in the facility, and to limit, to the extent possible, everyone's risk of exposure. I understand that it is my responsibility to inform any emergency contact persons of the information contained herein and that they cannot pick up my child unless they also have signed this form.

2. ____I understand that IF there is an emergency requiring me to enter the Mt Zion UMC Preschool facility beyond the designated drop-off and pickup area I MUST wash/sanitize my hands before entering and wear a mask at all times. While in the facility, I must practice social distancing and remain at least six (6) feet away from all other people, except for my own child.

3. ____I understand that to enter the facility my child must be free from COVID-19 symptoms. If any of the following symptoms appear during school, my child will be separated from others in the facility. I will be contacted by Mt Zion UMC preschool staff as soon as possible and my child must be picked up from the facility within thirty (30) minutes of being notified.

Symptoms include cough, shortness of breath, chills, muscle aches, headache, sore throat, loss of taste or smell, diarrhea, and/or fever of 100.0 degrees Fahrenheit or higher.

Though many of these symptoms can also be related to non-COVID-19 issues, it is imperative that we proceed with an abundance of caution during this public health emergency. These symptoms typically appear two to seven days after being infected.

4. ____I understand that individuals (such as children, parents, guardians, and emergency contacts) who have been diagnosed with COVID-19, had symptoms of COVID-19, or otherwise have reason to believe that they have contracted COVID-19; and who want to return to Mt Zion Preschool **before** completing a 14-day self-isolation, must present the director with a medical professional's certification of good health that clears the individual for return.

5. ____I agree to wear a face covering while dropping off and picking up my child(ren) until otherwise notified by Mt Zion UMC preschool.

6. ____I understand that my child's temperature must be taken prior to entering the facility at Mt Zion UMC preschool. I understand that the person responsible for dropping my child off at Mt Zion UMC preschool will be responsible for taking my child's temperature in the presence of a staff member. This number may be recorded for informational purposes.

7. ____I understand that my child will be required to wash their hands using CDC recommended hand washing procedures throughout the day using warm running water and soap for at least 20 seconds. I understand that teachers are not allowed to facilitate the use of hand sanitizer.

8. ____I understand the importance of complying with state, county or local stay-at-home and social distancing orders, even when outside of care, in order to control my child's exposure in the local community.

9. ____I will immediately notify the Mt Zion UMC preschool director should my child, or any member of our household, come into contact with someone that exhibits symptoms of COVID-19, tests positive for COVID-19, has been advised to self-quarantine, or is presumed positive for COVID-19. Further, I will immediately notify the Mt Zion UMC preschool director if anyone from my place of employment is presumed positive or tests positive for COVID-19, and I have been physically present in my place of employment within the last 14 days.

10. ____I understand and agree that if my child is diagnosed with COVID-19, Mt Zion UMC preschool must notify the state's licensing agent and the Maryland Department of Health.

11. ____I understand that while present in the facility my child may be in contact with others who are also at risk of community exposure. I understand that no restrictions, guidelines, or practices will completely remove the risk of exposure to COVID-19, as the virus can be transmitted by persons who are asymptomatic and before symptoms arise. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein, as well as those put forth by local governments.

12. ____I understand and accept all risks and responsibility for any injury to my child(ren) or myself (including but not limited to personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may incur in connection with my child's attendance at Mt Zion UMC preschool (“claims”) arising from COVID-19 or related illness.

13. ____On behalf of myself and my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless Mt Zion UMC preschool, Mt Zion UMC church, their employees, agents, and representatives, of and from any claims, including all liabilities, claims, actions , damages, costs or expenses of any kind arising from COVID-19 or related illness.

14. ____I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Mt Zion UMC preschool, as well as their employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after attendance at Mt Zion UMC preschool.

I certify below that I have read, understand, and voluntarily agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or

with any other policy or procedure outlined by Mt Zion UMC preschool may result in termination of all Mt Zion UMC preschool services. I acknowledge that care for my child may be terminated if it is determined that my actions, or lack of action, unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____ DOB:_____

Child's Name: _____ DOB:_____

Child's Name: _____ DOB:_____

Parent Name: _____

Parent Signature: _____ Date: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Emergency Contact Name: _____

Signature: _____ Date: _____

Emergency Contact Name: _____

Signature: _____ Date: _____

Mt Zion UMC Preschool representative: _____

Date: _____