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)
- ☐ 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

Procare SOLUTIONS

Child Information

Registration Date _____

1st Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

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

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain a photo of your child for security purposes?
[ ] Yes [ ] No

2nd Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

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

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain a photo of your child for security purposes?
[ ] Yes [ ] No

3rd Child

Last Name	First Name	M.I.	Nickname

Entering grade	[ ] Male [ ] Female [ ] Prefer not to specify	Birth Date	Birth City/State City: State:	Social Security #

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

Allergies

Pediatrician's Name	Phone	Address

Photos: May we take and maintain a photo of your child for security purposes?
[ ] Yes [ ] No

Additional Comments & Information: _____

Primary Guardian Information

Name(s) of person(s) with whom child is living

1st Primary Guardian				
Last Name	First Name	M.I.	Relationship to Child	
Email Address	Work Phone		Cell Phone	
Occupation	Employer	Work Address		Work Hours
2nd Primary Guardian				
Last Name	First Name	M.I.	Relationship to Child	
Email Address	Work Phone		Cell Phone	
Occupation	Employer	Work Address		Work Hours

Which Guardian Should be Called First?	Home Phone	Preferred language for written communication:	
Home Resident Street Address	Apt #	City	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 Name	M.I.	Relationship to Child	
Email Address	Work Phone		Cell Phone	
2nd Non-primary Guardian				
Last Name	First Name	M.I.	Relationship to Child	
Email Address	Work Phone		Cell Phone	

Which Guardian Should be Called First?	Home Phone		Should mailings 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	[ ] 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 would be helpful to our management and teaching staf?

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. 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.*

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

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 DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

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

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

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

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

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

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

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

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

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

Comments:

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

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

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

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

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21120
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.