Preschool Enrollment Packet

2026-2027 School Year

Fellowship Christian School

First day of school is Monday, August 24th, 2026

Preschool Program Age Requirements (Nonnegotiable)		
Class	Age	Birthdate By
P2.5	2.5 years	February 29, 2024
P3	3 years	August 31, 2023
P4	4 years	August 31, 2022

Important Note on Enrollment Procedure:

Your child remains unenrolled until all required forms and fees have been submitted.

Required Registration Forms	Committed Deadline/ Important Notes
☐ 1. Tuition Worksheet Form (Complete with the Office) ☐ 2.Student Information ☐ 3. Parent Guardian Agreement ☐ 4. Student Pick-Up Authorization ☐ 5. Health & Medical Form (Health Insurance Information) ☐ 6. ACH Payment Authorization Form	
☐ 7. MSDE Health Inventory Form and Immunization ☐ 8. MSDE Emergency Form (must add your initials if signed before June or in the previous school year before school starts) ☐ 9. Signed Student Handbook Agreement ☐ 10. Copy of Birth Certificate	
Required Fees	☐ ACH Fee - $25 ☐ Enrollment Fee - $300

Fellowship Christian School admits students of any race, color, national origin and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national origin and ethnic origin of its educational policies, admission policies, athletic, and other school administered programs.

FCS PRESCHOOL TUITION 2026-2027

TUITION				
Class	**Days Per Week**	**Length**	**Hours**	**10 Month Tuition**
P2.5	5 days	Full Day	9:00 am – 3:00 pm	$9,500
P3	5 days	Full Day	9:00 am - 3:00 pm	$7,930
P4	5 days	Full Day	9:00 am - 3:00 pm	$7,930

ADDITIONAL SCHOOL FEES		
Non-Refundable Enrollment Fee	Fees to be paid for enrollment and administrative fees	$300
ACH Payment Setup Fee	ACH setup fee for payment options for monthly bank withdrawals or monthly credit transactions	$25

TUITION DISCOUNTS (only 1 applies per family)	
☐ Additional Sibling Discount ☐ NCFC Member Discount (Verification of active membership is required)	10% off

EXTENDED CARE					
Program Type		**Days**	**Length**	**Hours**	**10 Month Fees**
1	Before care	5 days	AM	7:00 am - 8:50 am	$1,700
2	Afterschool	5 days	PM	3:10 pm - 4:30 pm	$2,200
3	Before-care and Afterschool	5 days	AM & PM	7:00 am - 8:50 am 3:10 pm - 4:30 pm	$3,350
4	After school and Aftercare	5 days	PM	3:10 pm - 6:00 pm	$3,650
5	Full Extended Care	5 days	AM & PM	7:00 am - 8:50 am 3:10 pm - 6:00 pm	$3,900

- **<u>Extended Care Program Details</u>**
  Partial or temporary enrollment in any of our Extended Care Programs is offered, depending on availability, after the first day of school. Pricing is higher when enrolling in short-term or partial-week daycare.
- Daycare availability may vary depending on when school closes. When offered, a minimum number of student is required, and an additional cost will apply.

Yearly enrolled Extended care Student: Half-day Daycare $50 Full-day Daycare $70
Non-Extended care Student: Half-day Daycare $50 Full-day Daycare $70

1. Tuition Worksheet Form

2026-2027 Preschool School Year

Fellowship Christian School

Class	Program		Check	Base Tuition
P2.5		9:00 am - 3:00 pm		$9,500
P3		9:00 am - 3:00 pm		$7,930
P4		9:00 am - 3:00 pm		$7,930
Extended Care Programs				
Beforecare	5 days	AM 7:00 am - 8:50 am		$1,700
Afterschool		PM 3:10 pm - 4:30 pm		$2,200
Beforecare & Afterschool		AM & PM 7:00 am - 8:50 am, 3:10 pm - 4:30 pm		$3,350
Afterschool & Aftercare		PM 3:10 pm - 6:00 pm		$3,650
Full Extended Care		AM & PM 7:00 am - 8:50 am, 3:10 pm - 6:00 pm		$3,900

Calculation Table			
*Enrollment ☐ $300	Program Base Tuition		$
* ACH Form & Fees $25 ☐ N/A ☐	*Enrollment $300 ☐		$
Payment by Vouchers: (CCS ☐ WPA☐)	Tuition Discounts:		-$
Payment Method: ☐ Check # _____ ☐ CC	Extended Care Program Fees		$
	Credit Card Fees *(3.6% CC Fee)*		$
Payment Options: *(please circle)* Option 1 Option 2 Option 3 Option 4	**TOTAL AMOUNT (TO BE PAID)**		$

** Indicates non-refundable fees*

Tuition Worksheet Form Agreement

I confirm the tuition and fees as stated above. I agree to notify the office of any desired program change and understand any program changes made during the year in any FCS program will incur a $35 processing fee. Early student withdrawal will incur a pro-rated tuition fee plus an additional 10% of the remaining annual tuition.

_____ Parent Name

_____ Student Name

_____ Parent/Guardian Signature

_____ Date

FCS Enrollment Packet

2026-2027 School Year

2. Student Information

Applying for (Circle one): **Preschool** (P2.5 P3 P4) **Elementary** (K 1st 2nd 3rd 4th 5th)

Student Information		
Last Name:	First Name:	Gender: Male Female
Birth Date:	Birth City, State, Country:	
Home Address:		
Student Race:	Language(s) Spoken at Home:	
Name of the previous school: Phone Number:		
List any siblings/their ages, and indicate if siblings attended FCS:		
Has your child ever been referred to Child Find or screened for developmental delays? Y / N		
Has your child ever been released from a school for disciplinary or behavioral problems? Y / N		
If yes for either of the above, please explain: **Please provide any previous report cards, IEPs, or progress reports for the student.*		

Parent/Guardian Information must be filled out below, indicate "N/A, none, or same as…" but do not leave blank.

Mother/Guardian	Father/Guardian
Full Name:	Full Name:
Relationship to student:	Relationship to student:
Marital Status: Single or Divorced / Married	Marital Status: Single or Divorced / Married
Email:	Email:
Employer:	Employer:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Address if different than the student:	Address if different than the student:
Home church or other religious affiliation:	Home Church or other religious affiliation:

Parent's Signature _____ *Date* _____

FCS Enrollment Packet

2026-2027 School Year

Fellowship Christian School

3. Parent/Guardian Agreement

- I give permission for my child to take part in all school activities, including on and off-campus. I understand that alternate childcare will not be provided if I choose for my child not to participate in the given activity.
- I give permission for my child to be photographed, videotaped, or interviewed for possible use in school/church websites, school publications, and newspapers.
- I understand it is my responsibility to provide medical/dental insurance to cover my child for injuries that may occur during school-related activities. I will not hold FCS or NCFC responsible for medical/dental fees should my child incur an injury at school or during a school-related activity.
- I give authorization to Fellowship Christian School to use my email address, mailing address, and phone numbers for notices, events, newsletters, or reminders.

I choose one of the following payment options:

☐ **Option I** – Full payment by August 12 – No ACH fee.

☐ **Option II** – Semi-annual payments – Make two payments: 1st payment by August 12 and 2nd payment by January 12 – No ACH fee.

☐ **Option III** – Ten monthly payments transferred from a checking or savings account via ACH: first payment in August and last payment in May. ACH withdrawals occur on the 20th of each month. (Includes $25 ACH set-up fee.)

☐ **Option IV** – Ten monthly payments transferred from a credit card via the ACH payment system: first payment in August and last payment in May. ACH withdrawal occurs on the 20th of each month. An additional 3.6% is assessed on each payment using a credit card. (Includes one-time $25 ACH set-up fee.)

As the parent/guardian of _____, I agree to follow the policies and procedures outlined above and in the FCS Parent/Student Handbook to the best of my ability and will encourage my child to do the same.

_____ _____

Signature of Parent or Guardian **Date**

FCS Enrollment Packet

2026-2027 School Year

4. Student Pick-up Authorization

Student Name: _____

Please fill out the following information of the individuals who have the parent/guardian's permission to be entrusted to pick-up your child from school. The following individuals should be over 18 and be ready to provide personal identification at the time of pickup. If none is listed below, your child will only be released to you.

Name of Authorized Person	Telephone Number	Relationship to Student

By signing below, I approve and authorize the above individuals I have written to pick up my child from school on any given day. I authorize my child to be released to the following list of individuals on any given day. I am responsible for updating any information as necessary at the school office.

Signature of Parent/Guardian: _____ **Date:** _____

5. Health and Medical Form

This form is used in addition to the mandatory Maryland Health Inventory and Emergency Form. The more complete information you provide, the better we are able to work with your child to ensure he/she receives the needed care.

Please type or write clearly and legibly.

Name of Child: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)

Health Insurance Information (Family insurance is the primary insurance in case of accident or illness)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Does child suffer from any medical/physical problem, limitation, or disability of which the school should be aware? (i.e. muscle/blood conditions, asthma, epilepsy, etc.) Yes ☐ No ☐ If yes, please list and explain below:

Allergies: Please provide a note from your child's doctor if he/she is allergic to any food that the school should be aware of and prohibit in certain classrooms. Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of Last Reaction

Does your child require an inhaler, epipen, or other medications? Yes ☐ No ☐

If medications need to be administered during school hours, parents must submit a Medical Administration Authorization Form (2015 version) from the Maryland State Department of Education filled out by the child's physician.

Explain any restrictions of participation in program or activities: _____

HEALTH INFORMATION PRIVACY STATEMENT

The Health and Medical Form is for health care concerns for use at Fellowship Christian School and school-related activities. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. Your signature below indicates that you have read the above procedures for handling the health and medical form and agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

MEDICAL RELEASE AND AUTHORIZATION STATEMENT

Your signature below also authorizes Fellowship Christian School to contact (at your expense) the physician listed to render necessary emergency treatment for injury or accident if neither parent/guardian can be reached. This further authorizes Fellowship Christian School to administer First Aid and/or transport your child to a local physician of the school's choice if your physician is not available. In the event that emergency treatment is necessary, Fellowship Christian School will be held harmless in all decisions. In case of disaster, your child will only be released to those persons listed in the emergency information section. Parents are expected to provide medical/dental insurance to cover their child for any injury that may take place at school and during any school related activity and may not hold Fellowship Christian School or New Covenant Fellowship Church responsible for medical/dental fees, should an injury at school or during a school-related activity. (This includes holding FCS and NCFC harmless for any expenses not covered by parent or guardian's insurance policies.)

This Health and Medical Information Form is complete and accurate. My child has permission to engage in all scheduled activities by FCS, except as noted by me in writing.

Signature of Parent/Guardian: _____ **Date:** _____

6. ACH Payment Authorization Form

*Please attach a voided check. There is a yearly fee of $25.00.

Student Name: _____

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

Total Due: _____ Payment Frequency: _____

# of Payments: _____ Start Date: _____

Payment Amount:_____

I _____ authorize FELLOWSHIP CHRISTIAN SCHOOL to charge my bank account or
(full name)

credit card indicated.

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

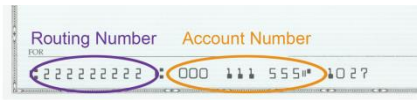
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify FELLOWSHIP CHRISTIAN SCHOOL in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that FELLOWSHIP CHRISTIAN SCHOOL may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

7. MSDE 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 health care provider per COMAR 13A.15.03.04, 13A.16.03.04, 13A.17.03.04, and 13A.18.03.04. A Physical Examination form designated by the Maryland State Department of Education and the Maryland Department of Health shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02, 13A.17.03.02 and 13A.18.03.02).
- **Evidence of immunizations**. The immunization certification form (MDH 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: https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 896.
- **Evidence of Blood-Lead Testing for children younger than 6 years old**. The blood-lead testing certificate (MDH 4620) or another written document signed by a Health Care Practitioner shall be used to meet this requirement. This form can be found at:https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms Select MDH 4620.
- **Medication Administration Authorization Forms**. If the child is receiving any medications or specialized health care services, the parent and health care provider should complete the appropriate Medication Authorization and/or Special Health Care Needs form. These forms can be found at: Select Forms OCC 1216 through OCC 1216D as appropriate. https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide 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 providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

Part I of this Physical Examination form must be completed by the child's parent or guardian. Part II must be completed by a physician or nurse practitioner, or a copy of the child's physical examination must be attached to this form.

If the child does not have health care insurance or access to a health care provider, or if the child requires an individualized health care plan or immunizations, contact the local Health Department. Information on how to contact the local Health Department can be found here: https://health.maryland.gov/Pages/Home.aspx#

The Child Care Scholarship (CCS) Program provides financial assistance with child care costs to eligible working families in Maryland. Information on how to apply for the Child Care Scholarship Program can be found here: https://earlychildhood.marylandpublicschools.org/child-care-providers/child-care-scholarship-program

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:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	**Name:**	**Name:**	☐ **Yes** ☐ **No**	**Physical Exam:**
Address:	**Address:**	**Address:**	**Child Care Scholarship**	**Dental Care:**
Phone:	**Phone:**	**Phone:**	☐ **Yes** ☐ **No**	**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	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

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.

_____
Printed Name and Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Health Care Provider

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

1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition?
☐ No ☐ Yes, describe:

2. Does the child receive care from a Health Care Specialist/Consultant?
☐ No ☐ Yes, describe

3. 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:

4. Health Assessment Findings

Physical Exam	**WNL**	**ABNL**	**Not Evaluated**	**Health Area of Concern**	**NO**	**YES**	**DESCRIBE**
Head	☐	☐	☐	Allergies	☐	☐	
Eyes	☐	☐	☐	Asthma	☐	☐	
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐	
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐	
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐	
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐	
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐	
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	
Neurological	☐	☐	☐	Mobility Device	☐	☐	
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐	
Skin	☐	☐	☐	Physical illness/impairment	☐	☐	
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐	
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐	
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐	
Hematology	☐	☐	☐	Developmental Disorder	☐	☐	
Developmental Milestones	☐	☐	☐	Other:			

REMARKS: (Please explain any abnormal findings.)

5. Measurements	Date	Results/Remarks
Tuberculosis Screening/Test, if indicated		
Blood Pressure		
Height		
Weight		
BMI % tile		
Developmental Screening		

6. 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).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

7. Should there be any restriction of physical activity in child care?
☐ No ☐ Yes, specify nature and duration of restriction:

8. Are there any dietary restrictions?
☐ No ☐ Yes, specify nature and duration of restriction:

9. **RECORD OF IMMUNIZATIONS** – MDH 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: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

10. **RECORD OF LEAD TESTING -** MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 4620)

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd 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 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: _____

LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	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	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #10
									DOSE #3		DOSE #3			

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local/state health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

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 DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. 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.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

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 BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments
	Select a test type.		
	Select a test type.		
	Select a test type.		

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes☐ No☐ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes☐ No☐ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes☐ No☐ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes☐ No☐ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes☐ No☐ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes☐ No☐ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes☐ No☐ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

Maryland
STATE DEPARTMENT OF EDUCATION

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

Maryland
DEPARTMENT OF HEALTH

This order is valid for one year from the date of prescriber's signature below.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed annually, for each medication, or when there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

Maryland State Department of Education
Office of Child Care
MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				**Date of Birth:**	
Medication Name:				**Dosage:**	
Route:				**Time to Administer:**	
DATE ADMINISTERED	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

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☐

8. 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.*

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

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

9. HANDBOOK AGREEMENT

We, the parents of _____, have read and agree to follow the rules and standards outlined in this handbook, as well any future policies and procedures developed at Fellowship Christian School that we are made aware of, to the best of our abilities.

We have read and understood Fellowship Christian School's ***Statement of Faith***. It is the non-negotiable foundation for all FCS does and teaches. This statement of faith governs all procedures and policies and will be upheld in our school.

We agree to reinforce the school's expectations with our child and do our best to cooperate with the school administration, staff, and teachers. We understand that failure to comply with the school's policies could result in warnings, fees, or the dismissal of our child from Fellowship Christian School. We understand the school's desire to carry out a Christ-centered, educationally rich environment for all students and will consistently strive to support the children, teachers, and staff prayerfully.

_____ _____

Parent/Guardian Signature Date

11. Statement of Faith

(AS STATED IN THE NEW COVENANT FELLOWSHIP CHURCH'S STATEMENT OF BELIEFS)

This statement of faith is to be signed annually and in good conscience by every member of the Faculty, Staff, and Parents.

1. We believe God has revealed himself to be the living and true God, perfect in love and righteous in all His ways; one in essence, existing eternally in the three persons of the Trinity: Father, Son, and Holy Spirit.
2. We believe the Bible, both Old and New Testaments, is the inspired, infallible Word of God. It is, therefore, our final authority in matters of our faith, practice, and conduct.
3. We believe God, by His word and for His glory, freely created the world from nothing. He made man and woman in His own image, as the crown of creation, that they might have fellowship with Him. Tempted by Satan, they rebelled against God. Being estranged from their Maker, yet responsible to Him, they became subject to divine wrath, inwardly depraved, and, apart from grace, incapable of returning to God.
4. We believe the only Mediator between God and humankind is Christ Jesus our Lord, God's eternal Son, who being conceived by the Holy Spirit and born of the Virgin Mary, fully shared and fulfilled our humanity in a life of perfect obedience as true God and true man. By His death in our stead, He revealed the divine love and upheld divine justice, removing our guilt and reconciling us to God. Having redeemed us from sin, the third day He rose bodily from the grave, victorious over death and the powers of darkness. He ascended into heaven where at God's right hand, He intercedes for His people and rules as Lord over all.
5. We believe the Holy Spirit, through the proclamation of the gospel, renews our hearts, persuading us to repent of our sins and confess Jesus as Savior and Lord. By the same Spirit we are led to trust in divine mercy, whereby we are forgiven all our sins, justified by faith alone through the merit of Christ our Savior, and granted the free gift of eternal life.
6. We believe God graciously adopts us into His family and enables us to call Him Father. As we are led by the Spirit, we grow in the knowledge of the Lord, becoming transformed into Christ's image, and endeavoring to live in the world that all may see our good works and glorify our Father Who is in heaven.
7. We believe the true Church is composed of all such persons who through saving faith in Jesus Christ have been regenerated by the Holy Spirit and are united together in the body of Christ. The church is summoned by Christ to offer acceptable worship to God and to serve Him by preaching the gospel and making disciples of all nations, by tending the flock through the ministry of the Word and ordinances and through daily pastoral care, by striving for social justice and by relieving human distress and need. For such work, members of the Church are to be a vital and committed part of a local church. And further, that every local church has the right under Christ to decide and govern its own affairs.
8. We believe water baptism and the Lord's Supper are the ordinances to be observed by the Church during this present age. They are not regarded as means to salvation.
9. We believe God's redemptive purpose will be consummated by the visible, glorious, imminent return of Christ to raise the dead, rapture the church, to judge all people according to the deeds done in the body, and to establish His glorious kingdom. The wicked shall be separated from God's presence, but the righteous in glorious bodies, shall live and reign with Him forever. Then shall the eager expectation of creation be fulfilled and the whole earth shall proclaim the glory of God, Who makes all things new.

Statement on Marriage, Gender, and Sexuality

- We believe that God created each person as male and female. These two distinct gender together reflect the image and nature of God. (Gen 1:26-27)
- We believe that the term marriage means the uniting of one man and one woman in an exclusive union as defined in Scripture. (Genesis 2: 18-25)
- We believe that God offers restoration and redemption to all who confess and turn away their sin seeking His mercy and forgiveness thorough Christ, Jesus. (Acts 3:19-21, Romans 10:9-10, 1 Corinthians 6: 9-11)
- We believe that it is vital that all FCS staff and parents agree to and abide to this Statement on Marriage, Gender, and Sexuality. (Acts 3:19-21; Romans 10:9-10; 1 Corinthians 6:9-11)

Parent Name_____ **Parent Signature**_____

FCS Student(s):_____ _____**Date**_____