


### First day of school is Monday, August 24<sup>th</sup>, 2026

Elementary Program Age Requirements (Nonnegotiable)		
Class	Age	Birthdate By
Kindergarten	5 years	August 31, 2021
1 <sup>st</sup> Grade	6 years	August 31, 2020
2 <sup>nd</sup> Grade	7 years	August 31, 2019
3 <sup>rd</sup> Grade	8 years	August 31, 2018
4 <sup>th</sup> Grade	9 years	August 31, 2017
5 <sup>th</sup> Grade	10 years	August 31, 2016

### **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
<ul style="list-style-type: none"> <li><input type="checkbox"/> 1. Tuition Worksheet Form (Complete with the Office)</li> <li><input type="checkbox"/> 2. Student Information</li> <li><input type="checkbox"/> 3. Parent Guardian Agreement</li> <li><input type="checkbox"/> 4. Student Pick-Up Authorization</li> <li><input type="checkbox"/> 5. Health &amp; Medical Form (Health Insurance Information)</li> <li><input type="checkbox"/> 6. ACH Payment Authorization Form</li> </ul>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> 7. MSDE Health Inventory Form and Immunization</li> <li><input type="checkbox"/> 8. MSDE Emergency Form (must add your initials if signed before June or in the previous school year before school starts)</li> <li><input type="checkbox"/> 9. Signed Student Handbook Agreement</li> <li><input type="checkbox"/> 10. Copy of Birth Certificate</li> <li><input type="checkbox"/> 11. Signed Statement of Faith</li> </ul>	
<p><b>Required Fees</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> ACH Fee - \$25</li> <li><input type="checkbox"/> Enrollment Fee - \$250</li> <li><input type="checkbox"/> Book Fee – Kinder \$300, 1<sup>st</sup>-5<sup>th</sup> - \$475</li> </ul>

*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 ELEMENTARY TUITION 2026-2027

TUITION										
Class	Academic Program			10 Month Tuition						
K – 5 <sup>th</sup> Grade	School Days: Monday – Friday			\$ 8,100						
	School Hours: 8:50 am – 3:20 pm									
	School Year Dates: August 24 <sup>th</sup> 2026 – June 10 <sup>th</sup> 2027									
ADDITIONAL SCHOOL FEES										
Non-Refundable Enrollment Fee	Enrollment Fees are paid one-time at the beginning of enrollment each year.			\$ 250						
Book Fee (Non-refundable after July 31, 2026)	Kindergarten Book Fee Due by May 31, 2026			\$300						
	1 <sup>st</sup> -5 <sup>th</sup> Book Fee Due by May 31, 2026			\$475						
ACH Payment Setup Fee	ACH setup fee for payment options for semi-yearly, monthly bank withdrawals, or monthly credit transactions.			\$ 25						
TUITION DISCOUNTS (only 1 applies per family)										
<input type="checkbox"/> Additional Sibling Discount <input type="checkbox"/> NCFC Active Member Discount				<b>10% off</b>						
EXTENDED CARE ANNUAL FEES										
Program Type	Days	Length	Hours	Fees						
Beforecare	5 days	AM	7:00 am - 8:30 am	\$1,700						
Afterschool	5 days	PM	3:20 pm - 4:30 pm	\$2,500						
Beforecare and Afterschool	5 days	AM & PM	7:00 am - 8:30 am 3:20 pm - 4:30 pm	\$3,350						
Afterschool and Aftercare	5 days	PM	3:20 pm - 6:00 pm	\$3,650						
Full Extended Care	5 days	AM & PM	7:00 am - 8:30 am 3:20 pm - 6:00 pm	\$3,900						
<ul style="list-style-type: none"> <li>• <b>Extended Care Program Details</b>            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.</li> <li>• Daycare availability may vary depending on when school closes. When offered, a minimum number of students is required and there will be an additional cost.</li> </ul>										
<table> <tr> <td><b>Yearly enrolled Extended care Student:</b></td> <td>Half-day Daycare \$50</td> <td>Full-day Daycare \$70</td> </tr> <tr> <td><b>Non-Extended care Student:</b></td> <td>Half-day Daycare \$50</td> <td>Full-day Daycare \$70</td> </tr> </table>					<b>Yearly enrolled Extended care Student:</b>	Half-day Daycare \$50	Full-day Daycare \$70	<b>Non-Extended care Student:</b>	Half-day Daycare \$50	Full-day Daycare \$70
<b>Yearly enrolled Extended care Student:</b>	Half-day Daycare \$50	Full-day Daycare \$70								
<b>Non-Extended care Student:</b>	Half-day Daycare \$50	Full-day Daycare \$70								

# 1. Tuition Worksheet Form

2026-2027 Elementary School Year



Class	Program			Check	Base Tuition
Elementary	5 days	Full Day	8:50 am - 3:20 pm		\$8,100
Extended Care Programs					
Beforecare	5 days	AM	7:00 am - 8:30 am		\$1,700
Afterschool		PM	3:20 pm - 4:30 pm		\$2,500
Beforecare & Afterschool		AM & PM	7:00 am - 8:30 am 3:20 pm - 4:30 pm		\$3,350
Afterschool & Aftercare		PM	3:20 pm - 6:00 pm		\$3,650
Full Extended Care		AM & PM	7:00 am - 8:30 am 3:20 pm - 6:00 pm		\$3,900
Calculation Table					
* Enrollment <input type="checkbox"/> \$250	Program Base Tuition				\$
* Book Fee Kinder <input type="checkbox"/> \$300					
* Book Fee 1st-5th <input type="checkbox"/> \$475					
* ACH Form & Fees \$25 <input type="checkbox"/> N/A <input type="checkbox"/>					
<b>Payment Method:</b> <input type="checkbox"/> Check # _____ <input type="checkbox"/> CC _____	Tuition Discounts:		- \$		
	Extended Care Program Fees		\$		
<b>Payment Options: (please circle)</b> Option 1   Option 2 Option 3   Option 4	Credit Card Fees (3.6%)		\$		
	<b>TOTAL AMOUNT (TO BE PAID)</b>		<b>\$</b>		

*\* 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 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup>)

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:		
<i>*Please provide any previous report cards, IEPs, or progress reports for the student.</i>		

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 \_\_\_\_\_

### **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.

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*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: 1<sup>st</sup> payment by August 12 and 2<sup>nd</sup> 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 20<sup>th</sup> 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 20<sup>th</sup> 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.

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**Signature of Parent or Guardian**

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**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.

<b>Name of Child:</b> (Last, First, Middle Initial)	<b>Date of Birth:</b> (XX/XX/XXXX)
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**Health Insurance Information** (Family insurance is the primary insurance in case of accident or illness)

<b>Policy Holder's Name:</b>	<b>Policy Number:</b>
<b>Insurance Company Name:</b>	<b>Group Number:</b>
<b>Insurance Company Address:</b>	<b>Insurance Company Phone:</b>

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.

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### Please complete the information below:

**Total Due:** \_\_\_\_\_ **Payment Frequency:** \_\_\_\_\_

**# of Payments:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

Payment Amount: \_\_\_\_\_

I \_\_\_\_\_ (full name) authorize FELLOWSHIP CHRISTIAN SCHOOL to charge my bank account or 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.

## 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**

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
Last			First		Middle
<b>Address:</b> _____					
Number		Street		Apt#	City
State			Zip		
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>		<b>Phone Number(s)</b>	
		W: _____		C: _____	
		W: _____		C: _____	
<b>Medical Care Provider</b> Name: _____ Address: _____ Phone: _____		<b>Health Care Specialist</b> Name: _____ Address: _____ Phone: _____		<b>Dental Care Provider</b> Name: _____ Address: _____ Phone: _____	
				<b>Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Child Care Scholarship</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Last Time Child Seen for Physical Exam:</b> <b>Dental Care Specialist:</b>	
<b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.					
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding/Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where, Why)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening/Anaphylactic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, attach the appropriate OCC 1216 form.					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
Printed Name and Signature of Parent/Guardian _____					Date _____

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

<b>Child's Name:</b>			<b>Birth Date:</b>			<b>Sex</b>	
Last	First	Middle	Month / Day / Year			M <input type="checkbox"/>	F <input type="checkbox"/>
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child receive care from a Health Care Specialist/Consultant? <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
4. Health Assessment Findings							
<b>Physical Exam</b>	<b>WNL</b>	<b>ABNL</b>	<b>Not Evaluated</b>	<b>Health Area of Concern</b>	<b>NO</b>	<b>YES</b>	<b>DESCRIBE</b>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Dental/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Device/Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Device	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition/Modified Diet	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:			
<b>REMARKS:</b> (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? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis: <b>(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).</b> <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a>							
7. Should there be any restriction of physical activity in child care? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
8. Are there any dietary restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
9. <b>RECORD OF IMMUNIZATIONS</b> – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <b>or</b> a computer generated immunization record must be provided. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> Select MDH 896.)							
10. <b>RECORD OF LEAD TESTING</b> - MDH 4620 or other official document is required to be completed by a health care provider. (This form may be obtained from: <a href="https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms">https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms</a> 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](http://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](http://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/Da y/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

- Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Medical provider, local/state health department official, school official, or child care provider only)
- Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_
- 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 ( $\mu\text{g}/\text{dL}$ ). 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  $\geq 3.5 \mu\text{g}/\text{dL}$ , 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)

<u>Allegany</u>	<u>Baltimore Co. (Continued)</u>	<u>Carroll</u>	<u>Frederick (Continued)</u>	<u>Kent</u>	<u>Prince George's (Continued)</u>	<u>Queen Anne's (Continued)</u>
ALL	21212	21155	21776	21610	20737	21640
	21215	21757	21778	21620	20738	21644
<u>Anne Arundel</u>	21219	21776	21780	21645	20740	21649
20711	21220	21787	21783	21650	20741	21651
20714	21221	21791	21787	21651	20742	21657
20764	21222		21791	21661	20743	21668
20779	21224	<u>Cecil</u>	21798	21667	20746	21670
21060	21227	21913			20748	
21061	21228		<u>Garrett</u>	<u>Montgomery</u>	20752	<u>Somerset</u>
21225	21229	<u>Charles</u>	ALL	20783	20770	ALL
21226	21234	20640		20787	20781	
21402	21236	20658	<u>Harford</u>	20812	20782	<u>St. Mary's</u>
	21237	20662	21001	20815	20783	20606
<u>Baltimore Co.</u>	21239		21010	20816	20784	20626
21027	21244	<u>Dorchester</u>	21034	20818	20785	20628
21052	21250	ALL	21040	20838	20787	20674
21071	21251		21078	20842	20788	20687
21082	21282	<u>Frederick</u>	21082	20868	20790	
21085	21286	20842	21085	20877	20791	<u>Talbot</u>
21093		21701	21130	20901	20792	21612
21111	<u>Baltimore City</u>	21703	21111	20910	20799	21654
21133	ALL	21704	21160	20912	20912	21657
21155		21716	21161	20913	20913	21665
21161	<u>Calvert</u>	21718				21671
21204	20615	21719	<u>Howard</u>	<u>Prince George's</u>	<u>Queen Anne's</u>	21673
21206	20714	21727	20763	20703	21607	21676
21207		21757		20710	21617	
21208	<u>Caroline</u>	21758		20712	21620	<u>Washington</u>
21209	ALL	21762		20722	21623	ALL
21210		21769		20731	21628	
						<u>Wicomico</u>
						ALL
						<u>Worcester</u>
						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. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Name</span> <span>Title</span> </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Signature</span> <span>Date</span> </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"><b>Clinic/Office Name, Address, Phone</b></div> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
2. _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Name</span> <span>Title</span> </div> _____ <div style="display: flex; justify-content: space-between; margin-left: 40px;"> <span>Signature</span> <span>Date</span> </div>	

**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

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





**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

## 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 through 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 \_\_\_\_\_