Kent County Public School
Initial Registration Form

Part 1 – Student Information

Student Name (First, Middle, Last)	
DOB	
Place of Birth	
Gender (M, F, or Non-Binary)	
Street Address	
City/State/Zip	
Home Phone	
Primary Language of Student	
Primary Language in Home	

Will Student Ride a Bus? ☐ Yes ☐ No

Is McKinney-Vento Applicable? ☐ Yes ☐ No

Has student ever been enrolled in KCPS? ☐ Yes ☐ No

If so, is student "Unaccompanied Youth?" ☐ Yes ☐ No

What grade will your student be entering? ______

Is student in Informal Kinship Care? ☐ Yes ☐ No

***McKinney-Vento or Informal Kinship Care requires signed affidavits**

Evidence of Birth (MUST check one): ☐ Birth Certificate/Registration ☐ Passport/Visa ☐ Physician Certificate ☐ Other(MUST be legal form)

Ethnicity Identification:

Is Student Hispanic or Latino? ☐ Yes ☐ No

Race Identification: (Check as many as appropriate):

☐ (01) American Indian/Alaska Native
☐ (02) Asian
☐ (03) Black/African American
☐ (04) Native Hawaiian/Other Pacific Islander
☐ (05) White

Does the Student Have an IEP (Special Education) or 504 Plan? ☐ Yes ☐ No

Was the Student Enrolled in Any Other Special Program? ☐ Yes ☐ No
(If Yes, Please Specify: ____)

Is the Student Under Current Suspension or Expulsion From Prior School? ☐ Yes ☐ No

Name of Last School Attended	
Last Day of Attendance	
Contact Person	
School Telephone	

Early Care and Education Experience Prior to Kindergarten (Please check only one):

☐ Head Start ☐ Home/Informal Care ☐ Family Child Care ☐ Child Care Center
☐ Pre-kindergarten ☐ Even Start ☐ Non-Public Nursery School ☐ HIPPY(Home Instruction Program For Preschool Youngsters)

Part 2 – Proof of Residency

Is parent/guardian a bona fide resident of Kent County Maryland? ☐ **Yes** ☐ **No**

Proof of Residency must be provided prior to enrollment. If student/family is not McKinney-Vento, and is not a resident of Kent County, please contact Student Services for tuition information.

Proof of Residency (Must check and attach one):

☐ **Utility Bill (electric, gas, water, landline telephone)** ☐ **Property Lease/Mortgage Agreement**
☐ **Property Tax Bill** ☐ **Other (Must have approval from Student Services. Please indicate:**
____)

9-09

Part 3 – Parent/Guardian Information

☐ Mother ☐ Guardian	☐ Father ☐ Guardian
Name:	Name:
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Email:	Email:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Employer:	Employer:

Part 4 – Family Information

Other Significant Adults Living at the Residence:

Name:	Relationship:
Name:	Relationship:

Siblings:

Name	Birthdate

Part 5 - Health & Immunization Information:

Is immunization record complete? ☐ Yes ☐ No

☐ DHMD 896 Form Completed/Approved by School Nurse (Name/Date: ______________________)

☐ Temporary Approval of record by other School Official (Name/Date: ______________________)

As required by law for all students entering MD public schools for the first time, has the child received a physical exam in the past 9 months? ☐ Yes ☐ No If "NO", please list reason: ☐ finances, ☐ lack of access, ☐ other (please indicate: ______________________)

Please list any health concerns (medications, allergies, medical conditions, etc)

Part 6 - Emergency Contacts:

Name	Relationship	Phone 1	Phone 2

Part 7 – Disclaimer

Student, ______________________________, has been enrolled on the basis of the information provided by the parent/guardian.

Parent/Guardian Signature/Date:	
School Official Signature/Date:	

For School Use Only:

Attendance Zone School:	**Student ID#**
Assigned School:	**SS#**
Grade:	**AM Bus:**
KCPS Enrollment Date:	**PM Bus:**

NOTES:

Kent County Public Schools

Growing a Community of Leaders

The Maryland State Department of Education (MSDE) requires Kent County Public Schools to collect information about the early care experiences of all newly enrolling Preschool, Pre-Kindergarten and Kindergarten students. Please provide the following information to complete the chart below.

Child's Name ____ Date of Birth ____/____/_____

Grade (please circle one): Preschool Pre Kindergarten Kindergarten

Predominant Prior Care- In what kind of early care setting did your child spend **most** of his/her time since last September? (Check the boxes that apply.)

Prior Care	Full Day	Half-Day (Morning)	Half-Day (Afternoon)
Informal Care/**Home or Care by a Relative** - Child has been cared for exclusively at home or by a relative since last September. *Non-regulated care provided in a home by a relative or non-relative.*			
Head Start: *A federal preschool program for 3- to 5-year-olds from low- income families; funded by the U.S. Department of Health and Human Services and licensed by the Maryland Department of Education, Office of Child Care.* **Which center**? ___ Chestertown, ___ Rock Hall			
KCPS Pre-Kindergarten: *Public school prekindergarten education for 4-year-olds; administered by local boards of education and regulated by MSDE according to COMAR 13A.06.02 Prekindergarten Programs.*			
Check which school your child attended from the list below. _____ Garnet _____ Rock Hall _____ Galena			
Child Care Center - Child care was provided in a center, usually non-residential. *A facility, usually non-residential, that provides care to children for part or all of the day in the absence of a parent. The centers are licensed by MSDE, Office of Child Care.*			

Family Child Care Center -Child care in a residence other than the child's home where the provider was paid for the service. *Regulated care given to a child younger than 13 years old, in place of parental care for less than 24 hours, in a residence other than the child's residence and for which the provider is paid. Family child care is regulated by MSDE, Office of Child Care.*			
Non-Public Nursery School -Preschool programs with an "education" focus for 3 & 4 year-old children, usually part-day, nine months a year. Not a part of Kent County Public Schools. *Preschool program with an "education" focus for 2-, 3-, or 4-year-olds; approved or exempted by MSDE; usually part-day, nine months per year.*			
Kindergarten- The student is repeating Kindergarten.			

Thank you!

4/17/23

Transportation File **Please Print**

Race 1 2 3 4 5
1-American Indian
2-Asian
3-Black or African American
4-Native Hawaiian/ other Pac Islander
5-White

Date ____________________

Gender F or M
Circle one

School ____
for district locations:www.*infofinderi.com*

Grade P-K or K
Circle one

Student's Name ____
Last First Middle

Student's Date of Birth ____________________
Month Day Year

Name of Parent(s) or Guardian(s): ____

Student's Home Address: ____
Street; physical location P.O. Box

____
City State Zip

Please note that future address changes can only be changed at the school level with proof of residency.
Telephone Numbers: It is important for the Bus Drivers to have a reachable telephone number.
Only the # 1 telephone number will be listed on the School Bus Roster for the bus driver to contact a parent.

Telephone # 1 ______________________ *Circle one* home / cell / business Name ______________________
Telephone # 2 ______________________ *Circle one* home / cell / business Name ______________________
Telephone # 3 ______________________ *Circle one* home/ cell / business Name ______________________
Email Address ____

Revised 04/24/2014

Kent County Public Schools
Transportation Location Change Form
(This Form Does Not Grant Out Of Zone Placement)

BOE Policy allows one consistent A.M. pick up location and one consistent P.M. drop off location. For consideration of your request for bus service to or from different consistent pick-up or drop-off locations, please provide the following information (please print): **A requested change remains in effect from one school year to the next until another request is made for a change of pick up and/ or drop off. This request would also include returning to your home address**

Student's Name: ______________________________ Name of School: ______________________

Student's Grade ________ Parent's Name ______________________________

Home Address: ______________________________ Phone Work: ______________________
street

______________________________ Phone Home: ______________________
city state zip

(Optional) e mail address ______________________ Phone Cell: ______________________

ONLY ONE STUDENT PER FORM, if more than one student is listed, form will be returned for correction.

A.M. Pickup	Physical Address:
	Contact: Phone:
P.M. Drop-off	Physical Address:
	Contact: Phone:

Note: Parent is to return this completed form to the Transportation Department, 5608 Boundary Ave Rock Hall MD 21661, or fax to (410) 778-1705 allowing a minimum of 5 working days for processing. During summer months routes are being prepared and notification will be prior to the start of school. Change of service will not begin until authorization is received from the Transportation Department.

Parent's Signature ______________________________ **Date:** ________

(I understand that filing this form is only necessary if a change is requested)

Walk with younger children to and from the school bus stop, using this opportunity to teach the children proper pedestrian practices. If the parents cannot accompany their children arrangements should be made, if possible, for older children (brothers, sisters, or neighbors) to escort the younger children to and from the school bus stop. Pre-K and K students must have someone meet them at the bus stop. Parents who do not meet this request may be liable for monetary consequences, if the student has to be returned to the school. Arrive at the bus stop (5) minutes before scheduled arrival times of the bus.

Transportation Department Only: ☐ Parent ☐ School ☐ Bus Driver

☐ **Approved** ☐ **Denied** **Comments/Reasons**: ______________________

A.M. Bus #__________ P.M. Bus #__________

Effective Date: ______________

2023-24 Educational Benefit Form

July 1, 2023 - June 30, 2024

Complete one application per household. For more information, reference attached instructions or call 410-778-7174

Step 1

List all enrolled children. (If more spaces are required for additional names, attach another sheet of paper)

First and Last Names of ALL ENROLLED Children	Check (✓) All that apply:						School Information:	
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start	School Name	Grade

Step 2

Do any Household Members (including you) currently participate in one or more of the following assistance programs: Supplemental Nutrition Assistance Program (SNAP), Temporary Cash Assistance (TCA) or Medicaid?

Check one: **Yes** ☐ **No** ☐

Step 3

List Names and Income for ALL Household Members.

List ALL Household Members (including yourself) even those who do not receive income. For each Household Member who receives income, report total amount and how often for each source in whole dollars only. If they do not receive income from any source, write "0" or leave any fields blank you are certifying (promising) that there is not income to report.

How often = Weekly, Bi-Weekly, Twice a Month, Monthly or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): ☐☐

Step 4

Contact Information and Adult Signature:

I certify (promise) that all information on this application is true and that all income is reported.

Phone:	Printed Name:
Street Address:	Signature:
City, State & Zip	Date:

Step 5

OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (Check one or more):

☐ American Indian or Alaskan Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

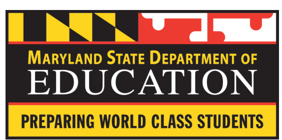
DO NOT FILL OUT THIS SECTION. SCHOOL USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ ______________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: ______________________ Date: ____________



Maryland Schools Record of Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** *A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement. (*http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** *A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at: https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20Immunization%20Certification%20Form%20(DHMH%20896%20-%20February%202014).pdf.*

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** *The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Lead/MarylandDHMHBloodLeadTestingCertificateDHMH4620_revised3.24.2016c.pdf.*

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

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

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf**. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene | Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip)	Phone No.
Parent/Guardian Names	
Where do you usually take your child for routine medical care? Name: Address:	Phone No.
When was the last time your child had a physical exam? Month Year	
Where do you usually take your child for dental care? Name: Address:	Phone No.

ASSESSMENT OF STUDENT HEALTH
To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?
No Yes Name(s) of Medications: ________

No Yes Treatment ____________________ , etc.)

Does your child require any special procedures? (catheteriz
No Yes
Parent/Guardian Signature __________________________ation, etc.)

Date:______________________

PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes ____

   ____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes____

   ____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No Yes ____
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ____

7. **Screenings**	**Results**	**Date Taken**
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name)____has had a complete physical examination and has:

no evident problem that may affect learning or full school participation   problems noted above

____

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE___________/_________/________

COUNTY ________________________________ SCHOOL______________________________________ GRADE_______

PARENT OR GUARDIAN NAME ____ PHONE NO. ____________________________

ADDRESS ____ CITY _____________________ ZIP________

Dose #	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
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
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	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				______	______	______	________	
5	DOSE #5								______ ______	______	______ ______	________ ________	

To the best of my knowledge, the vaccines listed above were administered as indicated.

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

2. ____
Signature Title Date

3. ____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

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: ________________________

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 BLOOD LEAD TESTING CERTIFICATE

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

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

CHILD'S NAME______________________ ______________ ______________
LAST FIRST MIDDLE

CHILD'S ADDRESS______________________ ______________ __________ __________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: Male Female BIRTHDATE______________ PHONE ______________

PARENT OR GUARDIAN ______________________ ______________ ______________
LAST FIRST MIDDLE

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

Was this child born on or after January 1, 2015? YES NO

Has this child ever lived in one of the areas listed on the back of this form? YES NO

Does this child have any known risks for lead exposure (see questions on reverse of form and talk with your child's health care provider if you are unsure)? YES NO

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

Parent or Guardian Name (Print): ____________________ **Signature**: ________________________ **Date**: ____________

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

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

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

Comments:

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

Provider Name: ______________________________ Signature:______________________________________

Date: ______________________________ Phone: ______________________________

Office Address: ____

BOX D – Bona Fide Religious Beliefs

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

Parent or Guardian Name (Print): ______________________ Signature: ________________________ Date: __________

****

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

Provider Name: ______________________________ Signature: ______________________________

Date: ____________ Phone: ______________

Office Address: ____

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

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

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

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

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
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 STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) ___________________ including the summer session.

School: ____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time 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.

<u>Prescriber's Authorization</u>

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 <u>signature</u> 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

2004

Safe at School®

Diabetes Medical Management Plan

(Add student photo here.)

SCHOOL YEAR:

STUDENT LAST NAME: FIRST NAME: DOB:

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PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):	Meals Times:	Physical Activity:	Travels to:
Foot/Bicycle	Breakfast	Gym	Home After School Program
Car	AM Snack	Recess	Via: Foot/Bicycle
Bus	Lunch	Sports	Car
Attends Before School Program	PM Snack	Additional information:	Student Driver
	Pre Dismissal Snack		Bus

Parent/Guardian #1 (contact first): Relationship: Parent/Guardian #2: Relationship:

Cell #: Home #: Work #: Cell #: Home #: Work #:

E-mail Address: E-mail Address:

Indicate preferred contact method: Indicate preferred contact method:

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG) Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set, Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies:

2. View Disaster/Emergency Planning details – refer to Safe at School Guide

3. Please review expiration dates and quantities monthly and replace items prior to expiration dates

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

Diabetes Medical Management Plan

STUDENT LAST NAME: FIRST NAME: DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter CGM (Requires Calibration)			
Carbohydrate Counting				
Insulin Administration:	Syringe Pen Pump			
Can Calculate Insulin Doses				
Glucose Management:	Low Glucose High Glucose			

Self-Carry Diabetes Supplies: Yes No Please specify items:
Smart Phone: Yes No

Device Independence: CGM Interpretation & Alarm Management Sensor Insertion Calibration Insulin Pumps Bolus Connects/Disconnects Temp Basal Adjustment Interpretation & Alarm Management Site Insertion Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:
Thirsty Frequent Urination Fatigued/Tired/Drowsy Headache Blurred Vision Warm/Dry/Flushed Skin
Abdominal Discomfort Nausea/Vomiting Fruity Breath Unaware Other:

Symptoms of Low:
None Hungry Shaky Pale Sweaty Tired/Sleepy Tearful/Crying Dizzy Irritable
Unable to Concentrate Confusion Personality Changes Other:

Has student lost consciousness, experienced a seizure or required Glucagon: Yes No If yes, date of last event:
Has student been admitted for DKA after diagnosis: Yes No If yes, date of last event:

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:
Before Meals With Physical Complaints/Illness (include ketone testing) High or Low Glucose Symptoms
Before Exams Before Physical Activity After Physical Activity Before Leaving School Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: Device Reader Smart Phone Insulin Pump Smart Watch iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian.
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.
May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm mg/dL

High alarm mg/dL if applicable

Section 1-5 completed by Parent/Guardian

Please:
- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:
- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable. (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)

above mg/dL (>300 mg/d DEFAULT)

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

Syringe
Insulin Pen (Whole Units Half Units)
Insulin Pump (Specify Brand & Model:)
i-Port
Smart Pen
Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
Other
Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

DOSING to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

Prior to Meal (DEFAULT)
After Meal as soon as possible and within 30 minutes
Snacking avoid snacking hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

Calculate meal dose using grams of carbohydrate prior to the meal
Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

Check for **KETONES** before administering insulin dose if BG > mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

Parents/guardians are authorized to adjust insulin dose +/- units

Insulin dose +/- units
Insulin dose +/- %
Insulin to Carb Ratio +/- grams/units
Insulin Factor +/- mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

Diabetes Medical Management Plan

STUDENT LAST NAME: FIRST NAME: DOB:

6A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) Other:

Ultra Rapid Acting Insulin: Fiasp (Aspart) Lyumjev (Lispro-aabc) Other:

Other insulin: Humulin R Novolin R

Meal & Times	**Food Dose**		**Glucose Correction Dose** Use Formula See Sliding Scale 6B	**PE/Activity Day Dose**
Select if dosing is required for meal	**Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	**Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose May give Correction dose every hours as needed (DEFAULT 3 hours)	**Adjust:** **Carbohydrate Dose** **Total Dose** Indicate dose instructions below:
Breakfast	Breakfast Carb Ratio = g/unit	**Breakfast** units	**Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
AM Snack	AM Snack Carb Ratio = g/unit No Carb Dose	**AM Snack** units No Insulin if < grams	**Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
Lunch	Lunch Carb Ratio = g/unit	**Lunch** units	**Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
PM Snack	PM Snack Carb Ratio = g/unit No Carb Dose	**PM Snack** units No Insulin if < grams	**Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units
Dinner	Dinner Carb Ratio = g/unit	**Dinner** units	**Target Glucose** is: mg/dL & **Correction Factor** is: mg/dL/unit **No Correction dose**	Carb Ratio g/unit Subtract % Subtract units

6B. CORRECTION SLIDING SCALE

Meals Only Meals and Snacks Every hours as needed

to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units
to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units
to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units

6C. LONG ACTING INSULIN

Time	Lantus, Basaglar, Toujeo (Glargine) Levemir (Detemir) Tresiba (Degludec) Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Subcutaneously

6D. OTHER MEDICATIONS

Time	Metformin Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Route

Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature: **Date:**

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

Allow student to carry and consume snacks School staff to administer

Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

Pre-programmed Temporary Basal Rate Named (Omnipod)

Temp Target (Medtronic) Exercise Activity Setting (Tandem) Activity Feature (Omnipod 5)

Start: minutes prior to exercise for minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: Student Trained School Staff School Nurse

May disconnect and suspend insulin pump up to minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

prior to exercise every 30 minutes during extended exercise following exercise with symptoms

Delay exercise if glucose is < mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

Fixed Snack: Provide grams of carbohydrate prior to physical activity if glucose < mg/dL

Added Carbs: If glucose is < mg/dL (120 DEFAULT) give grams of carbohydrates (15 DEFAULT)

TEMPORARY BASAL RATE as indicated above

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below mg/dL (below 70 mg/dL DEFAULT) or below mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)
Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

Glucagon Emergency Kit by IM injection Gvoke by SC injection Auto-Injection, Gvoke HypoPen
Dose: 0.5 mg or 1.0 mg

Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

Baqsimi Nasal Glucagon 3 mg

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
   a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
      - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
      - *Can return to class and PE unless symptomatic*
      - Recheck glucose and ketones in 2 hours

   b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
      - Contact parents/guardian or, if unavailable, healthcare provider
      - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
      - If using insulin pump change infusion site/cartridge or use injections until dismissal.
      - No physical activity until ketones have cleared
      - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
      - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: Date:

I, (parent/guardian) give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian: Date:

Acknowledged and received by:

School Nurse or Designee: Date:

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other: