2025 BES Summer Camp Program Ages 4+

Child's Name _____ DOB_____ T-Shirt Size_____

Circle One: Youth / Adult

Registration Date: _____

At the time of registration, there is a $300 NON-REFUNDABLE Activities Fee due. The Activities Fee will cover the costs for field trips, special visitors, and one camper T-shirt. Please choose the weeks your child will be attending and initial on the right. Camps operate Mon-Fri – no partial week rates available.

Weekly Camp Pricing	
Early Bird Weekly Tuition Rate 745am-515pm ** For members registered BEFORE 3/15/2025**	**$199**
Regular Weekly Tuition Rate 745am – 515 pm **Nonmembers or everyone AFTER 3/15/2025 **	**$219**
Add On Early Bird Care 645am – 745 am	$45
Add on Extended PM Care 515pm – 6pm	$30

By using the chart below, please mark which weeks your child will be in attendance. These weeks should match the selected weeks at the time of your online registration. Additionally, check if extended care is needed.

Week	Dates	Check each week 745-515	Add Early bird (645-745am)	Add Extended PM (515-6pm)	Weekly Total	Parent Initials
Week 1 – Express Yourself	6/16-6/20 (Closed June 19th)				$	
Week 2 – Aquatic Adventures	6/23-6/27				$	
Week 3 – Splash Into Summer	6/30-7/3 (Closed July 4th)				$	
Week 4 – Infinity & Beyond	7/7-7/11				$	
Week 5 – Color Your World	7/14-7/18				$	
Week 6 – Sports Extravaganza	7/21-7/25				$	
Week 7 – Wildlife Safari	7/28-8/1				$	
Week 8 – Game Show Mania	8/4-8/8				$	
Week 9 – Mad Scientists	8/11-8/15				$	
Week 10 – Global Expedition	8/18-8/22				$	
Week 11- Back-to-School Bash	8/25-8/28 (Closed August 29th)				$	

Summer Enrollment Confirmation

By signing below, I agree to all conditions of summer enrollment for my child at BES for Summer Camp 2025. Summer Camp runs Monday-Friday and will be closed on June 19th, July 4th, and August 29th.

Parent Signature_____ Date_____

For Office Use: _____ Activities Fee Pd Date _____ PPW Reviewed/Entered

Automated Payment Processing

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize Berlin Education Station to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 30 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Our center accepts all credit card types.

COMPLETE ONE SECTION ONLY

Section A (Credit Card)

_____ _____

Cardholder Name Phone #

_____ _____ _____ _____

Cardholder Address City State Zip

_____ _____ _____

Credit Card Number Expiration Date and Security Code

_____ _____

Cardholder Signature Date

Section B (Bank Account)

_____ _____

Your Name Phone #

_____ _____ _____ _____

Address City State Zip

_____ _____ _____ _____ _____

Bank or Credit Union Name Bank or Credit Union Address City State Zip

_____ _____

Routing Number Account Number Checking Savings

_____ _____

Authorized Signature Date

PARENT ACKNOWLEDGEMENTS

Please read and initial by each statement.

Sign the bottom of this form and return the completed packet to the office.

_____ **(initial)** I agree to enroll my child in the 2025 Summer Camp program at Berlin Education Station for the weeks indicated. **I understand that once I have registered for a camp week, it cannot be canceled or refunded.** Adding weeks may be possible based on availability. Please inquire with the Camp Director in advance.

_____ **(initial)** I will send my child to camp on field trip days wearing their camp T-shirt. I understand that if my child arrives without a camp shirt that I will be auto charged $20 for a replacement shirt.

_____ **(initial)** I understand that tuition will be processed on the Friday before each week of camp. I will either pay through the ProCare app or the card on file will be charged. I understand that if tuition is not paid on time, there will be a $15 late fee due with tuition before my child attends. I understand that if my tuition payment declines, a $35 decline fee will be added to my account and all fees will need to be paid in full for my child to attend. REMINDER – no cash or check payments. All payments made through ProCare.

_____**(initial)** I understand that cell phones and personal electronics are NOT permitted at BES during Summer Camp. If a child brings in an electronic device, it will be held at the BES front office and can be picked up by parents only. (If you require your child keeps a cell phone, it must be kept put away at all times and only used in case of an emergency. Twisters Inc is not responsible for lost, stolen, or damaged devices.)

_____**(initial)** I agree to allow Twisters, Inc to transport my child in BES vans or buses driven by BES staff members during summer camp activities. Additionally, some field trips may require school bus transportation services. I understand that Twisters, Inc will follow all OCC and DOT regulations and will not hold Twisters, Inc or any of its employees liable for any accidents or injuries.

_____**(initial)** I understand that my child must arrive at Summer Camp with sunscreen applied and that I must provide a labeled bottle of sunscreen to be used throughout the day or BES will apply our house sunscreen. I understand that staff will assist and remind my child to apply sunscreen as needed throughout the day.

_____**(initial)** I understand that my child must arrive at Summer Camp before 9:00 AM on field trip days to attend the field trip using BES transportation. If my child arrives late, I will need to transport them to the field trip myself or keep my child home and miss camp that day.

_____ **(initial)** I will not send my child to camp if he/she is not healthy enough to participate in all activities. I understand that my child must be symptom free (fever, vomit, diarrhea, rash, etc) for a complete 24 hours WITHOUT MEDICATION to be healthy enough to participate in camp activities.

_____ **(initial)** I affirm that I have received the BES Parent Handbook and will comply with all policies stated within.

Parent Name _____ Signature _____ Date _____

Berlin Education Station Summer Camp

Field Trip Permission Slip

Field Trip Permission Swimming Chart (please initial)

Pool/ Water Park	Level	Beach	Level
	Up to knees		Up to knees
	Up to Waist		Up to Waist
	Up to Chest		Up to Chest
	Overhead/ Swimmer		Overhead/ Swimmer

- **For water park or swimming field trips, if a child is 4 years old, we recommend a chaperone attends the field trip with them. To attend swimming and water park trips, campers must be able to swim.**

Child's Name:_____ Child's DOB:_____

I give_____ (Child's Name) permission to attend all field trips. I, _____(Parent/Guardian) understand that if I do not want my child to attend a specific field trip (or any field trips), that I must find alternate care for that day.

I,_____ (Parent/Guardian), give the Berlin Education Station Summer Camp permission to transport _____ (Child's Name) to and from any and all field trips. This may include field trips, mini day trips, etc. Berlin Education Station may also transport in the event of any emergency. I will not hold Berlin Education Station, Berlin Education Station Summer Camp, Twisters Inc., or any of its employees liable if accident, injury or death occurs.

_____

Parent Signature **Date**

Permission Agreements

- **Picture Permission Slip:**
  _____ (child's name) has permission to be photographed at the center's discretion for advertisement, press release purpose, and for the yearbook.

  Parent Signature: _____

- **Security Video Surveillance:**
  Berlin Education Station has my permission to videotape _____ (child's name) for security purposes.

  Parent Signature: _____

- **Handbook Receipt Acknowledgment:**
  I, _____ parent of _____ (child's name) have received a parent handbook and am aware of all rules and policies of Berlin Education Station. I will abide by the center rules at all times. I have received a copy of the Regulated Guide to Child Care in my enrollment packet.
  Parent Signature: _____

- **Sunscreen/Bug Spray Application Waiver**
  I, _____ parent of _____ (child's name) give permission for BES to apply sunscreen to my child.
  _____ (parent Initial) I acknowledge that I must provide sunscreen labeled with my child's name.

  Parent Signature: _____

- **Activity/Risk of Injury Waiver**
  I, _____ parent of _____ (child's name) am fully aware of and appreciate the risks, including the risk of catastrophic injury, paralysis and even death, as well as other damages and losses associated with participation in gymnastics/ninja activities and events. I further agree that Twisters Inc. and the sponsor of any Twisters Inc. events, along with the employees, agents, officers, and directors of these organizations shall not be liable for any losses or damages occurring as a result of my participation in any event, except where such loss or damage is the result of the intentional or reckless conduct of one of the organizations or individuals identified above.

  Parent Signature: _____

WAIVER FOR GYM USE

I, parent or legal guardian of the above child, hereby give approval and permission in any and all risk and hazard. Incidental to such participation and do herby waive, release, absolve, indemnity, and agree to hold harmless Twisters Inc., the employees, owners, supervisors, coaching instructors, and any subcontractors working with Twisters Inc. If my child has any physical condition that may impair their ability to engage in these activities, I will consult my physician prior to undertaking any physical exercise program. If necessary, I authorize Twisters Inc. to administer first aid and/or authorize medical treatment. Students are expected to carry their own medical and accident insurance. In signing, below, I agree to be responsible for any medical bills incurred during my child's participation at Twisters Inc. I give my permission for Twisters Inc. to take and use any photos of my child for the purpose of advertising or website use. This waiver of liability, having been read thoroughly and understood completely, is signed voluntarily as to its content and intent. By signing this release, I understand the policies and liabilities that may occur in sports activities. I understand there are no refunds or credits given. In the event of a legal dispute, I will pay all Twisters Inc. legal fees.

Parent Signature: _____ Date: _____

INSTRUCTIONS FOR COMPLETING MEAL BENEFIT APPLICATION – CHILD CARE CENTERS

Complete the application using the instructions below. Sign the form and return it to the center. If you need help, call [phone number].

STEP 1 – CHILDREN'S INFORMATION ALL HOUSEHOLDS COMPLETE

List the first and last name of all enrolled children. Indicate if a foster child, homeless, migrant, runaway, or in Head Start, Early Head Start or Even Start by checking the box. If **ALL** children listed are foster, homeless, migrant, runaway, or in Head Start, Early Head Start, or Even Start, skip to Step 4.

STEP 2 – CASE NUMBER

If **any** member of your household receives benefits from the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA), write the case number and skip to Step 4.

STEP 3 – NAMES OF ALL HOUSEHOLD MEMBERS AND GROSS INCOME

- List the first and last name of everyone in your household, whether they receive income or not. Your household includes all those living as one economic unit. Include yourself, all children living with you, including foster children and any other person living in your household, related or not. List each type of income received last month and how often it is received. You must indicate how much in whole dollars, and how often received (weekly, bi-weekly, twice a month, monthly, yearly). **If a household member has no income—write '0' in the income box**.
- Report all income as gross income. Gross income is the amount earned before taxes and other deductions. This is not the same as take- home pay. Gross income includes unemployment benefits, Worker's Compensation, Supplemental Security Income and Veteran's benefits, Social Security, private pensions or disability, strike benefits, income from trusts or estates, annuities, investment income earned interest, rental income and regular cash payments from outside household. For self-owned business, farm, or rental income, report income as **net income**.
- If you are in the Military Housing Privatization Initiative, do not include your housing allowance as income. Do not include combat pay.
- Indicate the total number of household members in the space provided.
- The form must have the last four digits of the Social Security Number of the primary wage earner or adult who signs unless the adult does not have a Social Security Number. If the adult does not have a Social Security Number, check the box. The last four digits of the Social Security Number are not needed if you listed a SNAP or TCA case number, or if you are only applying for foster children.

STEP 4 – SIGNATURE - ALL HOUSEHOLDS COMPLETE

All forms must have the signature of an adult household member.

STEP 5 – RACIAL/ETHNIC IDENTITY

You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.

Federal Income Eligibility Guidelines (Jul 1, 2025-Jun 30, 2026)

Household Size	Year	Month	Week
1	$28,953	$2,413	$557
2	39,128	3,261	753
3	49,303	4,109	949
4	59,478	4,957	1,144
5	69,653	5,805	1,340
6	79,828	6,653	1,536
7	90,003	7,501	1,731
8	100,178	8,349	1,927
For each additional family member add:	$10,175	$848	$196

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you are only applying for foster children, or you list a Supplemental Nutrition Assistance Program or Temporary Cash Assistance case number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them investigate violations of program rules.

This form is included in the packet twice because it must be renewed every July 1. Please complete BOTH if your children attend during both date ranges.

25-26 CA-CCC Sample

Child Care Centers

Meal Benefit Application

July 1, 2025 - June 30, 2026

Complete one application per household. For more information, read **Instructions for Completing** or call [phone number]

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 Do any Household Members (including you) currently participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)? Circle One: Yes No

If you answered **NO**, complete Step 3.

If you answered **YES**, provide a case number then go to Step 4

Case Number: ☐☐☐☐☐☐☐☐☐

Step 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, twice a Month 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): ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: ☐☐☐☐

Check if No SSN: ☐

Step 4 Contact Information and Adult Signature

I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

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 to 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. CENTER 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: _____

Date Withdrawn: _____

Child Care Centers

Meal Benefit Application

July 1, 2024 - June 30, 2025

Complete one application per household. For more information, read **Instructions for Completing** or call [phone number]

Step 1 List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 Do any Household Members (including you) currently participate in the Supplemental Nutrition Assistance Program (SNAP) or Temporary Cash Assistance (TCA)? Circle One: Yes No

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: ☐☐☐☐☐☐☐☐☐

Step 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, twice a Month 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): ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: ☐☐☐☐

Check if No SSN: ☐

Step 4 Contact Information and Adult Signature

I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

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 to 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. CENTER 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: _____

Date Withdrawn: _____

Maryland State Department of Education
Office of School and Community Nutrition Programs

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

Instructions for Completion:

- All parent/guardians are to complete this form for each child enrolled at the child care center/home participating in CACFP.
- List the child's name, birth date, the days and hours normally in care and the meals received while in care.
- CACFP Federal regulations require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

Name of Child Care Center/Home
Berlin Education Station and Berlin Activities Depot

1. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☑ ~~Saturday~~ ☐ ~~Sunday~~	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ ~~AM Snack~~ ☐ Lunch ☐ PM Snack ☐ Supper ☐ ~~Evening Snack~~

2. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ ~~Saturday~~ ☐ ~~Sunday~~	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ ~~AM Snack~~ ☐ Lunch ☐ PM Snack ☐ Supper ☐ ~~Evening Snack~~

3. Child's Name		Child's Date of Birth (MM/DD/YYYY)
Times Child Normally in Care (For example 7:30 AM – 5 PM) **Hours from:** _____ **to** _____	**Check (✓) the days your child normally attends:** ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☑ ~~Saturday~~ ☐ ~~Sunday~~	**Check (✓) the meals that your child will receive while in care:** ☐ Breakfast ☐ ~~AM Snack~~ ☐ Lunch ☐ PM Snack ☐ Supper ☐ ~~Evening Snack~~

Parent/Guardian Signature _____ Date Signed _____

Parent/Guardian's Name: _____ Phone: _____

Rev. 7/21

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered, or approved child care or nursery school:

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

EXEMPTIONS

Exemptions from a physical examination, immunizations, and Blood-Lead testing are permitted if the parent has an objection based on their bona fide religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner, or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care providers or child care personnel who have a legitimate care responsibility for the child.

INSTRUCTIONS

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

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

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

PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	**Name:**	**Name:**	☐ **Yes** ☐ **No**	**Physical Exam:**
Address:	**Address:**	**Address:**	**Child Care Scholarship**	**Dental Care:**
Phone:	**Phone:**	**Phone:**	☐ **Yes** ☐ **No**	**Specialist:**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

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

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

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

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

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

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
Printed Name and Signature of Parent/Guardian Date

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

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

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

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

3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
☐ No ☐ Yes, describe:

4. Health Assessment Findings

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

REMARKS: (Please explain any abnormal findings.)

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

6. Is the child on medication?
☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).
https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms

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

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

9. **RECORD OF IMMUNIZATIONS** – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: **https://earlychildhood.marylandpublicschools.org/child-care-providers/licensing/licensing-forms** Select MDH 896.)

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

Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

Additional Comments: _____

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

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:☐ No:☐

Meals your child will receive while in care:

BK☐ LN☐ SU☐ AM Snk☐ PM Snk☐ Evng Snk☐

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

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

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

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

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information_____

_____

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

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

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Address _____
Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____ Date _____

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

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: ____

____

____

____

<u>Note to Health Practitioner:</u>

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

______________________________ ______________________

Name of Health Practitioner Date

______________________________ (_____) ______________________

Signature of Health Practitioner Telephone Number

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

General Important Information

DROP-OFF/PICK-UP

Campers may be dropped off and picked up anytime in between the camp hours of 7:45AM and 5:15PM, unless you have paid for early bird or extended PM care.

- **DOOR CODES:** BES has a magnetic door lock system to access the facility. A code is required for entry. Your family will be given a door code that will only work for the time that your camper is enrolled in our programs. This is a unique code and is your responsibility to keep secure. Do not give this code to anyone that is not on your authorized pick up list.

- **SIGNING IN/OUT:** All campers must be signed in and out daily using the Procare system. You will receive registration information through your email.

- **LATE PICK-UP FEES:** Late pick up fees begin at 5:16pm unless your child is enrolled in Extended PM Care. $30 will be charged for the weekly Extended Care add-on if a child is picked up after 5:15. Extended PM Care ends at 6:00 and there will be a $5 per minute charge after this time.

- **PICK-UP AUTHORIZATION:** Campers will not be permitted to leave with someone that is not listed on their Emergency Form as an authorized pick-up and identification will be required. Please be aware of these rules as they are in the best interest of all children attending our camp. **BES must be notified by email from the parent/guardian if someone that is *not on the list* is picking up their child and that person will also need to show valid picture ID to staff.**

DAILY INFORMATION

- **CLOTHING:** BE COMFORTABLE. Campers should have a change of clothes, bathing suit & a towel with them each day just in case…. always dress for a mess – you never know what we might get into for the day!
- **CAMP BEHAVIOR:** Campers are expected to behave in a positive manner. All campers must treat other campers and camp staff with respect. Campers may be asked to use the "cozy corner" to calm themselves or have a "thinking time" away from the group if the director or a camp counselor feels it is necessary to redirect. We encourage children to own their emotions and will help them learn to self-regulate as much as possible. All behavior issues will be documented. If a child's behavior continues to be a problem, BES staff will contact parents and may have to send a child home. Disrespecting staff or counselors will NOT be tolerated. We will discuss our camp rules at length and children will know what is expected.
- **MEALS:** BES will provide breakfast, lunch, & an afternoon snack each day. NO outside food should be brought into the center; however, it may be necessary to pack lunches for field trips – we will notify you when this is necessary. If your child has any dietary restrictions or allergies, we will need an official Dietary Modification Form and will adjust our meals/snacks as needed for your child. Please see the BES office for more information. BES IS A PEANUT FREE FACILITY!
- **WATER BOTTLES:** Please send your child to camp each day with a labeled water bottle full of water only. We have water fountains for refilling throughout the day as needed. These bottles must be taken home each night and washed. Water bottles left at the end of the summer are disposed of.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Field Trips Information

- Every week Berlin Education Station Summer Camp will be embarking on field trips. The campers must be onsite in their camp t-shirt by **9:00 am** sharp to be ready for the trip. We will have additional offsite learning experiences and field trips throughout the Summer and will be sure to let you know when we embark on additional adventures.

- No camper will be permitted to attend a field trip without a signed permission slip.

- All campers going on the trips must be present at BES by **9:00 am** or as otherwise specified and MUST wear a BES Camp T-shirt. If your child does not have their shirt on, you will be auto charged for another one.

- All campers will attend field trips. There will not be a staff member at the center to care for them. If you do not want your child to attend a field trip, please, do not send them to BES that day.

- Each field trip's instructions and requirements may differ and will be provided to parents/guardians in advance, any changes to our itinerary will be given out that week of camp. If a parent wishes to join their child, they must pay the entry fee for themselves. We always welcome chaperones!

- **For water park or swimming field trips, if a child is 4 years old, we recommend a chaperone attends the field trip with them. To attend swimming and water park trips, campers must be able to swim.**

- Field trip fees are not refunded if your child does not attend the trip.

- BES reserves the right, without a refund, to refuse any child not exhibiting proper behavior to attend any given field trip or an individual chaperone may be required for the child to attend. There is no alternative care if a child is unable to attend a field trip.

- Tuition is based on a full summer budget and not on individual field trip costs. Field trips for students are covered by activity fees.

- Once all field trips have been confirmed and booked, we will send home a permission form with details that will need to be signed and returned to the office. We will have summer calendars with events & activities available by April and will send them out to all enrolled campers.