Welcome to King's Kids Early Learning Center

"Together we are building a brighter future for our children."

500 East Lincoln Avenue, Salisbury, MD 21804

(410) 341-7475

Dear Parent,

Thank you for considering King's Kids Early Learning Center for your child's care. We are proud members of Maryland EXCELS and serve children **ages 6 weeks to 12 years.**

We participate in the **Child and Adult Care Food Program, providing nutritious breakfast, snacks, and milk daily.**

We welcome children with special learning or healthcare needs. Our teachers thoughtfully design lesson plans to meet each child's individual needs.

Enrollment Requirements

Before your child is officially enrolled, please submit the following:

1. **Completed Physical Form** from your child's doctor
2. **Immunization Record**, including lead testing dates (if applicable)
3. **Enrollment Fee: $175 (Non-refundable)**
4. **We accept Maryland childcare scholarship (if applicable)**

Once these items are received, you'll be given an Enrollment Packet, which must be completed and returned on or before your child's first day.

We appreciate your cooperation and look forward to a joyful and successful experience with you and your child(ren).

Sincerely,

Robin Belote, Director

MISSION & PHILOSOPHY STATEMENT

At Kings Kids Early Learning Center, we are fully committed to creating a joyful, safe, and nurturing environment that supports the whole child—mentally, socially, emotionally, physically, and spiritually.

We believe every child is uniquely gifted and deserves a learning space that honors their individuality, cultural background, and developmental needs. Our holistic approach encourages children to explore, investigate, solve problems, and express themselves freely.

We maintain an open-door policy and welcome families as active partners in their child's growth. Our classrooms reflect multicultural diversity through books, toys, and materials that celebrate each child's heritage. Activities are thoughtfully balanced between teacher-guided and child-initiated experiences to foster independence and collaboration.

Our staff is dedicated to continuous professional development and strives to create a high-quality, inclusive program where every child can thrive. We proudly serve families in Wicomico County and surrounding areas—regardless of race, creed, color, or ethnicity—with excellence and compassion.

Revised

8/26/2025

Discipline Policy

King's Kids Early Learning Center promotes positive discipline techniques and respectful interactions. All staff, volunteers, and substitutes are trained annually and must adhere to the following standards:

- Model respectful behavior at all times
- Never use physical or emotional punishment
- Never leave children unsupervised
- Use a positive tone of voice
- No profanity under any circumstances
- Never withhold food as punishment
- Encourage children to try new foods, but never deny portions based on consumption
- Example: "Eat all your vegetables or you won't get dessert" is not permitted
- Acceptable behavior guidance includes:
- Gentle redirection
- Modeling appropriate behavior
- Parent collaboration
- Counseling and conversation with the child

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 _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

Note to Health Practitioner:

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

_____ _____

Name of Health Practitioner Date

_____ (____) _____

Signature of Health Practitioner Telephone Number

MARYLAND 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: Last First Middle Birth date: Mo / Day / Yr Sex M☐F☐

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 DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

CHILD'S NAME: _____
LAST FIRST MI

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

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

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

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

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

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

Lead Risk Assessment Questionnaire Screening Questions:

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

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

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

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

Office of Child Care

Allergy and Anaphylaxis

Medication Administration Authorization Plan

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY

Child Care Responsibilities:		
	1. Medication named above was received	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Card updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐ N/A
	6. Individualized Plan: IEP/IFSP	☐ Yes ☐ No ☐ N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Child and Adult Care Food Program

Center Name: Kings Kids Academy

Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/ or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period . Review completed enrollment form and enter the effective date in lower right hand section .

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child (ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ MONDAY									
LAST NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST ☐ A.M. SNACK
BIRTH DATE	☐ THURSDAY ☐ FRIDAY	Other:								☐ LUNCH ☐ P.M. SNACK
AGE	☐ SATURDAY ☐ SUNDAY	**Enrollment Date:**			**Withdrawal Date:**					☐ SUPPER ☐ EVENING SNACK

Signature

_____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY:

_____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) ***mail: U.S. Department of Agriculture***
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) ***fax: (202) 690-7442; or***

(3) ***email: program.intake@usda.gov***

This institution is an equal opportunity provider.

The Planning Council & MSDE Form

INFANT FEEDING PLAN (For children 0 - 12 mos.)

Center Name: Kings Kids Academy

Address: 500 E. Lincoln Avenue

Dear Parent(s)/Legal Guardian(s):

This center/provider offers _____ iron-fortified infant formula
Formula name
for all enrolled infants at no additional charge. It is your option whether or not to use this formula based on your preference and your infant's needs. All formula that is provided to infants at this facility must be iron-fortified as required by the Child and Adult Care Food Program.

PARENT FORMULA REQUEST

Please check one of the following options, **regarding FORMULA:**

_____I will provide expressed breast milk for my infant. I understand that the breast milk I supply must be labeled with my child's name and the date the milk was expressed.

_____I will use the infant formula offered by this facility.

_____I ***will not*** use the infant formula offered by the facility. I will supply the following Infant formula for my infant _____.
Formula name

I understand that I must supply sufficient infant formula each day to meet my child's needs. Bottles must be labeled with my child's name and be dated. Bottles must be taken home daily.

PARENT FOOD REQUEST

When your infant is developmentally ready to eat solid foods, do you accept or decline the provider/facility-supplied food?

Please check one of the following options, **regarding FOODS:**

_____I will supply all supplemental foods for my infant. [*Center may not claim my child for meals*]

_____I will **ACCEPT** the supplemental foods offered to my infant(s) by this facility.

Child's Name: _____

Child's Date of Birth: _____

_____ _____
Signature of Parent/Legal Guardian Date

All food and beverages served to infants in this facility must be in compliance with the infant meal pattern required by the Child and Adult Care Food Program.

Kings Kids Academy

20-21 Center MBA

Meal Benefit Application for Child Care Centers

July 01, 2025 - June 30, 2026

For more information, read **Instructions for Completing** or call: (855) 427-2888

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 Food Supplement Program (FSP) 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: _____

Center Name: Kings Kids Academy

Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/_____	3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐ URI ☐ Seasonal Allergies ☐Pollen ☐ Exercise ☐Animals ☐Dust ☐Smoke ☐ Food ☐Weather ☐Other_____

6. This authorization is NOT TO EXCEED 1 YEAR FROM____/____/____TO____/____/____
FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Breathing is good ☐No cough or wheeze ☐Can walk, exercise, & play ☐Can sleep all night If known, peak flow greater than _____ (80% personal best)					

Exercise Zone ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:

☐Prior to all exercise/sports ☐When the child feels they need it	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions

YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest ☐Cough or cold symptoms ☐Shortness of breath ☐Other:_____ If known, peak flow between ____ and _____ (50% to 79% personal best)					

RED ZONE - MEDICAL ALERT/DANGER ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Breathing hard and fast ☐Lips or fingernails are blue ☐Trouble walking or talking ☐Medicine is not helping (15-20 mins?) ☐Other:_____ If known, peak flow below _____ (0% to 49% personal best)					

Kings Kids Early Learning Center

Parent Agreement & Enrollment Terms

Building faith, nurturing growth, and partnering with families every step of the way.

1504 Pemberton Dr, Unit F, G, H, Salisbury, MD 21804

(410) 341-7475 kingskidsabc@gmail.com www.kingskidsacademyelc.com

1. Child & Family Information

- Child's Full Name: [_____]
- Date of Birth: [_____]
- Parent/Guardian Name(s): [_____]
- Primary Contact Number: [_____]
- Email Address: [_____]
- Start Date of Care: [_____]

2. Hours of Operation

Kings Kids Early Learning Center is open:

Monday–Friday, 7:30 AM – 5:30 PM

Children must be picked up by closing time. Repeated late pickups may result in termination of care.

Initial: [___]

3. Tuition & Fees

- Tuition is $[_____] per [week/month] and is due weekly on Mondays.
- Payment method: Brightwheel only
- Late fee of $[_____] per day applies if payment is not made on time.
- If payment is not received by Wednesday, enrollment may be terminated.

- Tuition is charged during all scheduled closures and when a child is absent, unless pre-arranged in writing.
- Scholarships and third-party payments must be confirmed prior to start date.

Initial: [___]

Closures

Kings Kids will be closed on all nationally recognized holidays and the last Wednesday, Thursday, and Friday of August for staff training.

Tuition will still be charged during these closure periods.

Initial: [___]

Trial Period

We offer a 90-day trial period for new enrollments. Either party may discontinue care during this time.

Initial: [___]

Termination & Withdrawal

Kings Kids may terminate care at any time without prior notice.

Families withdrawing must provide two weeks' written notice or pay two weeks' tuition.

Initial: [___]

Attendance & Absences

Notify us of absences by 9:00 AM. Tuition remains due regardless.

Initial: [___]

Health & Illness

Children must be symptom-free for 24 hours before returning.

Parents will be contacted for prompt pickup if illness occurs.

Initial (Sick Policy): [___]

9. Safety

Children are always supervised. Only authorized individuals may pick up.

Monthly fire/emergency drills are conducted.

Initial: [___]

10. Medication

Medication requires signed authorization and must follow Maryland Regulation 13A.15.11.04.

First doses must be given at home.

Initial: [___]

11. Field Trips & Walks

I give permission for my child to participate in supervised walks and field trips.

Initial: [___]

12. Screen Time

Children under 2 receive no passive screen time. Ages 2+ may have up to 30 minutes per week.

Initial: [___]

13. Positive Discipline

We use positive reinforcement, redirection, and reflection.

Initial: [___]

14. Parent Acknowledgments

I confirm receipt and understanding of the following:

- Parent Handbook

Initial: [___]

- **Maryland Infants and Toddlers Program Pamphlet**

Initial 1: [] Initial 2: [] Initial 3: [] Initial 4: []

- **Sick Policy**

Initial: [___]

- **Parents' Guide to Regulated/Licensed Child Care**

Initial: [___]

- **Arrival Policy**

I understand that no one will be permitted to enter the center after 9:00 AM unless documentation is provided explaining the reason for the late arrival.

Initial: [___]

Signatures

Parent/Guardian Signature: [_____ Date: _____

Center Director Signature: _____ Date: _____

For questions, concerns or to file a complaint contact your Regional Office

Regional Offices	Phone
Anne Arundel	410-573-9522
Baltimore City	667-354-5178
Baltimore County	410-583-6200
Prince George's	301-333-6940
Montgomery	240-314-1400
Howard	410-750-8771
Western Maryland, Allegany, Garrett & Washington	301-791-4585
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-819-5801
Lower Shore, Wicomico, Somerset & Worchester	410-713-3430
Southern Maryland, Calvert, Charles & St. Mary's	301-475-3770
Harford & Cecil	410-569-2879
Frederick	301-696-9766
Carroll	410-549-6489

The Regional Offices investigate complaints to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at CheckCCMD.org.

For additional help, you may contact the Director of Licensing at 410-767-0120.

Resources

Child Care Scholarship (CCS) - Assists eligible parents and families with child care expenses **1-877-227-0125** **money4childcare.com**

Maryland EXCELS - Maryland's Quality Rating System for child care programs **marylandexcels.org**

Maryland Developmental Disabilities Council - Assistance with ADA issues **md-council.org**

Maryland Infants and Toddlers Program - Early intervention services for young children with developmental delays and disabilities and their families **referral.mditp.org**

Maryland Family Network - Assists parents in locating child care **1-877-261-0060** **marylandfamilynetwork.org**

Maryland Child - Information about child development, parenting, community resources, mental health, nutrition, literacy, and more. **Marylandchild.org**

Maryland State Department of Education
Division of Early Childhood
200 West Baltimore Street
10th Floor
Baltimore, MD 21201
earlychildhood.marylandpublicschools.org

Wes Moore, Governor

Carey M. Wright, Ed.D
State Superintendent of Schools

Parent's Guide to Regulated/ Licensed Child Care

Information About Child Care Facilities

Maryland
STATE DEPARTMENT OF EDUCATION

Who Regulates Child Care?

All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's (OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care;
- Taking enforcement action when necessary; and
- Partnering with community organizations and consumers to keep all children in care safe and healthy.

Regulations governing the Maryland State Department of Education (MSDE) fall under COMAR Title 13A. Regulations that govern child care facilities and other information about the Office of Child Care may be found at:

earlychildhood.marylandpublicschools.org/child-care-providers/licensing

What are the types of Child Care Facilities?

Family Child Care – care in a provider's home for up to eight (8) children with no more than two under the age of two.

Large Family Child Care– care in a provider's home for 9-12 children.

Child Care Center – non-parental care in a group setting for part of a 24 hour day.

Letter of Compliance (LOC) – care in a child care center operated by a religious organization for children who attend their school.

All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department, and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Must maintain certification in First Aid and CPR;
- Must maintain approved staff and student ratio and provide ACTIVE supervision all times when children are in care;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills, and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury, or injurious treatment.

Did You Know?

- The provider's license or registration must be posted in a conspicuous place in the facility;
- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;
- Parents/guardians may visit the facility without prior notification any time their children are present;
- Written permission from parents/guardians is required for children to participate in any and all off property activities;
- All child care facilities must make reasonable accommodations for children with special needs;
- A qualified teacher must be assigned to each group of children in a child care center;
- Staff:child ratios must be maintained at all times in child care centers;
- Parents/guardian must be immediately notified if children are injured or have an accident in care;
- Parents/guardians may review the public portion of a licensing file; and
- Check Child Care Maryland, CheckCCMD.org, is a resource for parents and families to use to review child care provider's license status, verified complaints, compliance history, and inspection results.

DO YOU HAVE CONCERNS?

Visit referral.mditp.org to learn developmental milestones for young children and see if your child's growth and development are on track for his/her age. If you have concerns, don't hesitate to speak with your child's healthcare provider and/or child care provider and make a referral.

NEXT STEPS

1. Check out referral.mditp.org to learn more information and to complete an online referral. You can also call 800-535-0182 to get contact information for your local Infants and Toddlers Program.

2. You will want to share information about your concerns and priorities when you speak with your local Infants and Toddlers Program. Next steps will include planning for developmental screening and/or evaluation to help determine if your child is eligible for services.

3. If your child is eligible, you will become a part of the early intervention team. Together you will develop a plan for supports and services. These will be provided at no cost and in familiar places where your child learns and plays, such as your home, child care program, the park, or the library.

Anyone can submit a referral to the Maryland Infants and Toddlers Program available for eligible children younger than 36 months who live in Maryland.

referral.mditp.org
1-800-535-0182

Maryland
STATE DEPARTMENT OF EDUCATION

WE BEGIN EARLY TO FINISH STRONG

Maryland Infants and Toddlers Program

supporting young children with developmental delays or disabilities and their families

Maryland
STATE DEPARTMENT OF EDUCATION

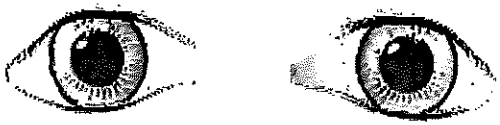
PARENTS:

Children will NOT be permitted into class after 9:00AM

Unless documentation is received.

Documentation includes but is not limited to: Court documents, doctor's notes, WIC appts, etc

CONJUNCTIVITIS



Healthy eye

Conjunctivitis

Does my child have conjunctivitis?

Conjunctivitis also known as pink eye can be irritated by infection or allergies.

Your child may return 24 hours after treatment.

- What to look for:
- Running discharge
- Sticky discharge
- Redness around the eye
- Rash
- Remember: Wash your hands and your child's hand is the best way to prevent illness.

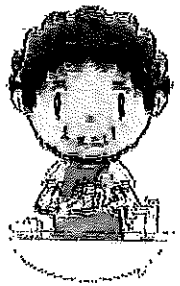
Stomach-ache, vomiting and diarrhea

What to do?

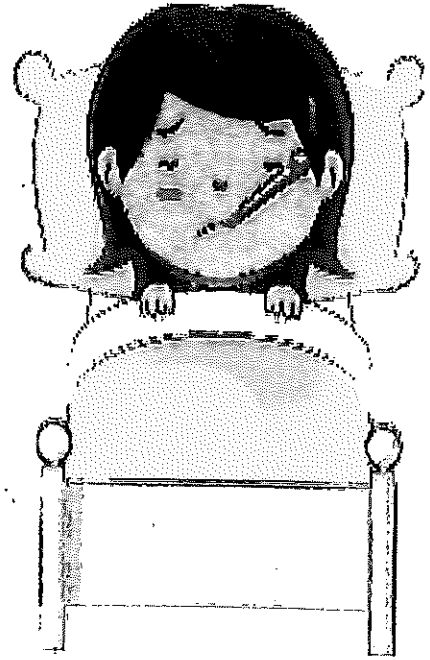
A child should be kept home for at least one day.

. Contact your doctor if fever and stomach pains last more than 24hours.

REMEMBER TO WASH HANDS FREQUENTLTY.



SHOULD YOUR CHILD BE IN CARE WITH AN ILLNESS?



SHOULD YOUR CHILD BE IN CARE WITH AN ILLNESS?

Robin Belote

King's Kids Academy

Does my child have a sore throat?

What is a sore throat?

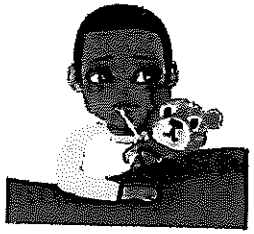
A sore throat is a pain, scratchiness, or irritation that causes hard swallowing.

Children typically contact a cold three to eight times per year, ten if they are in a child care setting. If cough, cold or fever is persistent call your child's doctor. Children may return to care after 24 hours.

<u>When you call your child's doctor know:</u>

- When symptoms began
- If the child has a fever
- Has your child been exposed to any serious illness?

Does my child have a fever?



Your child may not attend child care with a fever.

Fevers are signs of infection. Check with the child's doctor for the best medication to reduce fever.

Does my child have a rash?

A rash can be caused by different things, a virus, medication or chemical. Call your child's doctor if you notice a rash, you're not familiar with. Keep your child home from child care until you have discussed it with the doctor.

Is my child in pain?

<u>Earache</u>

If your child has an ear infection call your doctor. To relieve pain, give your child acetaminophen or ibuprofen as recommended by the doctor. If your child isn't in severe pain or doesn't have a fever, they may attend child care.

<u>Toothache</u>

Call your dentist.

<u>Headache</u>

Your child should stay home if headache doesn't respond to medication. Contact your doctor is headache is persistent.

Kings Kids Early Learning Center 📅 2025–2026 Closure Calendar.

🎉 **Center Closures**

🕛 New Year's Eve – December 31

- 🎆 New Year's Day – January 1
- 🕊️ Martin Luther King Jr. Day – Third Monday in January 20th
- **April:** Good Friday, Easter Monday
- Memorial Day – Last Monday in May 31st
- ✊ **Juneteenth** – June 19
- 🎇 Independence Day – **July 4**
- 🛠️ Labor Day – First Monday in **September**
- 🦃 Thanksgiving Day –Thursday in **November 26th 27th 28th**

• Christmas: December 24th to 31st

- 🗓️ All nationally recognized holidays
- 📚 **Annual Staff Training Closure – Last Wednesday, Thursday, and Friday of August**

📌 **Additional Notes**

• All national holidays are observed except Presidents Day

- **Families will be notified of any additional closures in advance.**
- **Tuition is still charged during closure periods.**
- **All messages and updates in 2025 will be sent through the Bright wheel app.**
- **If Wicomico County Public Schools are closed due to inclement weather, Kings Kids will also be closed.**