Stepping Stones
PRESCHOOL

Please enroll my child for the 2026-2027 school year. I understand that in order to have my application considered, I must attend a tour, New Parent interview and Observation Day, then submit a **non-refundable** registration fee**.** I also understand that Stepping Stones Preschool reserves the right to accept or decline enrollment of my child.

_____ _____

(Parent's Signature) (Date)

INSTRUCTIONS

1. Please complete one form per child.

2. Attach a separate payment for each form completed.

Student's Name _____

(Last First Middle)

Child resides with Mother Father Both

Home Address _____

City/State/Zip _____ Date of Birth _____

Home Phone _(___)_____

Father's Name _____ Mother's Name _____

Driver's License _____ Driver's License _____

Home Address _____ Home Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

Email Address _____ Email Address _____

Will your child need the following fee-based options? Early Stay Late Stay

Name of church of like faith and practice you attend

_____

Attendance is Faithful Occasional Seldom

Church's Address _____

City/State/Zip _____

Pastor's Name _____ Church Phone # _____



GETTING TO KNOW YOU

What is your name? _____

Do you have a nickname? What is it? _____

What is your favorite color? _____

What is your favorite treat/snack? _____

How many people are in your family? _____

Do you have a favorite animal? _____

Do you have a pet? What is his/her name? _____

Do you like to sing? What songs? _____

Are you ticklish? _____

What was your favorite vacation? _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.
(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.

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	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

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: _____

_____

_ _ _ _

STATEMENT OF FAITH

The basis for Stepping Stones Preschool and Daycare can be found in the Word of God interpreted by the following nine essentials:

1. We believe in the verbal inspiration and authority of the Scriptures. The King James Version of the Bible reveals God, the fall of man, the way of salvation, and God's plan and purpose for the ages. *Note: All students must use a KJV Bible.*

2. We believe there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.

3. We believe in the Deity and Virgin Birth of our Lord Jesus Christ, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, and His ascension to the right hand of the Father.

4. We believe in the visible, personal, and pre-millennial return of Jesus Christ.

5. We believe that salvation is "by grace" plus or minus nothing. The conditions to salvation are repentance and faith in Jesus Christ.

6. We believe that man is sinful and thereby separated from God. He is justified by faith alone and accounted righteous before God only through the merit of our Lord and Savior, Jesus Christ.

7. We believe in the resurrection of both the saved and the lost: the saved unto the resurrection of life and the lost unto the resurrection of damnation.

8. We believe in the eternal security of the believer in Christ.

9. We believe in the local church with the ordinances of baptism by immersion and the Lord's Supper.

MISSION AND PURPOSE OF STEPPING STONES PRESCHOOL & DAYCARE

Our goal is to assist parents and the church, by providing a quality, Christian education for young people that will encourage them to receive Jesus Christ as their personal Saviour and will motivate them to commit their lives to stand for Him in today's world.

COMMITMENT OF STEPPING STONES PRESCHOOL & DAYCARE

We are committed to families. We are privileged to serve God's creation, the family, and to assist parents in training their children.

We are committed to maintaining a safe and secure environment for our children and to challenge them daily in the Word of God.

We are committed to churches. We affirm the mission of a Bible-believing church, and of discipling people for Christ. We support local churches by encouraging loyalty to their ministries and by emphasizing the value of the life spent in the Gospel ministry in all of its facets.

We are committed to our students. We are bound by love to watch for their souls, to train our students in truth and righteousness, to protect and prepare them, to show them the way of salvation in Jesus Christ, to convey a Biblically-based and quality education, to demonstrate the Christian life in our words and actions, and to imitate the love of God in our relationships with them.

We are committed to our faculty. We are committed to provide an environment that allows them to minister freely and effectively, to encourage and honor excellence in the classroom, and to support their work with prayer and materials that will assist them in their efforts to strengthen their ministries.

We are committed to our community. As long as we are in the world, our name will be associated with honesty and integrity in our performance, concern for and submission to civil authority, and educated citizens who will make positive contributions to society in their role as salt of the earth. We will strive to present a testimony that will not shame the name of our Lord Jesus Christ.

PARENT STATEMENT OF COOPERATION

Parents of students at Stepping Stones Preschool and Daycare must agree to the following statements:

1. I have read the Statement of Faith and I am willing to have my child trained according to it. I commit to pray for the school and its leaders.

2. I realize it is the function of the school to assist parents in carrying out their God-given responsibilities in rearing their children.

3. I am aware that my cooperation is expected in regular tuition payments. If I am ever unable to pay on time, I will notify the school office giving a reasonable explanation for the delay, and state when the payment can be made.

4. I give permission for my child to take part in all school activities, including school-sponsored trips away from the school premises. I absolve the school from all liability in the event that my child is injured during any school activity or at school. I am aware that for me to chaperone field trips, I must adhere to the school's dress code.

5. I know that the school is the final authority on all matters of dress and grooming, and I agree to help the school enforce its dress code by sending my child(ren) to school dressed and groomed according to the dress code.

6. If I feel I am at odds with Stepping Stones Preschool and Daycare's school polices, I promise to go directly to the school office and seek to resolve the matter right away. If I do not agree with the policies in the handbook, specifically the discipline system, I will not try to change the policies, but will withdraw my child quietly and without delay.

7. I realize that the school has full discretion in the discipline of my child while he/she is under the supervision of the school. I understand, and concur with, the discipline steps of the school. I also realize the school will administer no form of corporal discipline.

8. If for any reason my child does not respond favorably to the discipline and academic systems of the academy, I will not try to change the school to fit his/her needs, but will withdraw my child quietly, and without delay.

9. Realizing tardies disrupt the class, embarrass the child, and cause him to get behind in his morning work, I will strive to be on time except in an emergency. Realizing any absence from school hinders my child's academic progress, I will only allow him/her to miss school in times of emergency, illness, or doctor's appointments.

10. I know that the administration reserves the right to withdraw any student from Independent Baptist Academy at any time, in the event the actions of the child or parent causes the administration to question the integrity of the student or parent.

Father's Signature _____ Date_____

Mother's Signature _____ Date_____

Student's Name: _____

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 DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

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

How To Use This Form

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

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

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, prekindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the

Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

Frequently Asked Questions

1. **Who should be tested for lead?**
   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.
2. **What is the blood lead reference value, and how is it interpreted?**
   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.
3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**
   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.
4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**
   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).
5. **What programs or resources are available to families with a child with lead exposure?**
   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.
   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx
   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

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

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-diphtheriaacellular 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 **"AgeAppropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME:

_____

LAST FIRST MI

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

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

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaPDT Mo/Day/Yr	Polio Mo/Day /Yr	Hib Mo/Da y/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #10
									DOSE #3		DOSE #3			

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

Clinic / Office Name

Office Address/ Phone Number

1. _____

Signature Title Date

(Medical provider, local/state health department official, school official, or child care provider only)

2. _____

Signature Title Date

3. _____

Signature Title Date

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

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____

Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date: _____

Medical Provider / LHD Official **RELIGIOUS**

OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

Maryland State Department of Education

Office of Child Care

Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**

This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.

Prescription medication must be in a container labeled by the pharmacist or prescriber.

Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

PRESCRIBER'S AUTHORIZATION

Child's Name:_____Date of Birth: ____/_____/_____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from:____/____/_____ to ____/____/_____

If PRN, for what symptoms, how often and how long _____

Possible side effects and special instructions**:** _____

Known Food or Drug Allergies: ☐ Yes ☐No If yes, please explain: _____ For School Age children only: The child may self-carry this medication: ☐ Yes ☐No

The child may self-administer this medication: ☐ Yes ☐No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the 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. **School Age Child Only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No**

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

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date _____ ☐ ☐ Yes No
2. Medication labeled as required by COMAR. ☐ Yes ☐No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐No ☐N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐No ☐N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐ N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

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

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

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

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

Stepping Stones
PRESCHOOL

Dear Parents,

We are working hard to make our Preschool the best it can be! In doing so, we post pictures on Facebook and our website of fields trips and special events that we have in class.

We are requesting your permission to post your child's picture for Stepping Stones advertising purposes. Please mark the appropriate box, sign and date this permission slip below. This document needs to be returned to the office as soon as possible.

We need a separate permission slip for each child. If you have any questions or concerns, please let us know.

Thank you so much!

T. Michael Creed
Pastor



☐ I am **willing** to let my child's pictures be used on the school's Facebook page and website.

☐ I am **NOT willing** to let my child's picture be used on the school's Facebook page and website.

Child's Name _____ Date _____

Parent's Signature _____ Date _____

Stepping Stones
PRESCHOOL

2026-2027 FINANCIAL SCHEDULE

Effective June 2026

REGISTRATION FEE- $200

This fee includes student insurance. The registration fee is due with the application and is non-refundable.

TUITION- $875 per month
Additional siblings: $795 per month

-Tuition payments are due on the 1st of each month. Automatic payments can be set up through the Gradelink system. If you have any questions regarding setting up automatic payments, please see the office.

-There is a $60.00 sevice charge for any check returned from the bank. Any account having a check returned will be placed on a cash or money order basis for the remainder of the year.

-If a past due payment as well as Early and Late Stay fees have not been received by the tenth of the month, a child will not be allowed to attend preschool until his/her account has been brought up to date. No financial adjustments can be made because of absences.

EARLY AND LATE STAY

The Early Stay program runs from 7:30 am - 8:00 am each school morning

The Late Stay program runs from 3:30 pm - 5:00 pm each afternoon. The cost for these services is:

	Per Use:	Discounted Monthly Rate:
Early Stay:	**$10.00/hour**	**$125/month**
Late Stay:	**$10.00/hour**	**$250/month**

A late fee of $10.00 and $1.00 per minute will be charged for each student not picked up 5:00 pm. Stepping Stones reserves the right to cancel Early/Late Stay if there is little or no interest.

All fees are subject to change at the discretion of the Stepping Stones Preschool and Daycare



Sample K3 Daily Schedule

8:00 – 8:30	Arrival
8:40 – 8:50	Morning Circle (Calendar and Jobs)
8:50 – 9:10	Bible
9:10 – 9:20	Bathroom Break
9:20 – 9:40	Snack
9:40 – 10:10	Phonics/Handwriting
10:10 – 10:40	Recess
10:40 – 10:50	Bathroom Break
10:50 – 11:10	Language Development
11:10 – 11:30	Centers (M)/Numbers (T-F)
11:30 – 11:40	Bathroom Break
11:40 – 12:10	Lunch
12:10 – 12:30	Recess
12:30 – 12:50	Skills development
12:50 – 1:00	Story/Reading
1:00 – 2:30	Nap
2:30 – 2:50	Bathroom/Snack
2:50 – 3:00	Review
3:00 – 3:30	Dismissal

Stepping Stones
PRESCHOOL

Sample K4 Daily Schedule

8:00 – 8:45	Arrival/Attendance (Centers)
8:45 – 8:55	Bathroom Break
8:55 – 9:20	Morning Snack
9:20 – 9:45	Circle Time (Songs/Bible Story)
9:45 – 10:15	Table Time (Phonics/Numbers/STEM)
10:15 – 10:25	Bathroom Break
10:25 – 11:00	Recess (Indoor – Gymnasium, Outdoor – Playground)
11:00 – 11:10	Bathroom Break
11:10 – 11:45	Lunch
11:45 – 11:55	Bathroom Break
11:55 – 12:10	Table Time (Handwriting/Reading)
12:10 – 12:20	Bathroom Break
12:20 – 12:50	Recess (Indoor – Gymnasium, Outdoor – Playground)
12:50 – 1:00	Bathroom Break
1:00 – 2:30	Nap Time
2:30 – 2:40	Bathroom Break
2:40 – 3:00	Review/Pack-up and Dismissal



PRESCHOOL SUPPLY LIST	
QUANTITY ITEMS NEEDED:	
1	**SMALL** blanket and **SMALL** pillow for nap time with a bag to store them in
2	Plastic pocket folders
1	Change of uniform – labeled with child's name (if used, must be replaced the next morning)
1	Book bag that will close completely (must fit a lunch box, extra uniform, folder, and bedding)
1	Lunch box (**OPTIONAL**) – pictures and designs must be in agreement with academy philosophies and teachings
1	Coloring book – *to be used as needed in the classroom*
2	22-gram glue sticks (large)
2	Boxes of 24 crayons – K4 only
1	4-pack of Play Dough
1	Reusable Water bottle
1	Package of Jumbo non-rolling crayons – K2 and K3 only
1	Pair of blunt Fiskars scissors – K3 and K4 only
All student supplies need to be labeled with the child's name.	

Stepping Stones
PRESCHOOL

2026-2027 School Calendar

(dates subject to change)

August 2026

August 7	**Half Day**
August 10-14	**No School:** Teacher Training and Certifications
August 13	Parent Orientation
August 17	First Day of School

September 2026

September 7	**No School:** Labor Day
September 25	Grandparent's Day
September 29	School Pictures

October 2026

October 23	**No School:** Annual Staff Training
October 29	Picture Retakes

November 2026

November 11	**No School**: Veteran's Day
November 24	Thanksgiving Lunch
November 25-27	**No School**: Thanksgiving Break

December 2026

December 18	Christmas Party – Noon Dismissal, No Late Stay
December 21-Jan 1	**No School**: Christmas Break

January 2027

January 4	**No School:** Teacher In-Service
January 5	School Resumes
January 18	**No School:** Martin Luther King Jr. Day

February 2027

February 15	**No School:** President's Day

March 2027

March 8-12	**No School:** Spring Break
March 26-29	**No School:** Easter Break

April 2027

April 30	Principal Appreciation Day

May 2027

May 4	Teacher Appreciation Day
May 24-28	**No School:** Summer Teacher Work Week
May 31	**No School**: Memorial Day

June 2027

June 18	**No School:** Juneteenth

July 2027

July 2	**No School:** July 4th

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