Stepping Stones PRESCHOOL

Please enroll my child for the 2025-2026 school year. I understand that in order to reserve space for my child I must pay the **non-refundable** registration fee along with this form. 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 complete.

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

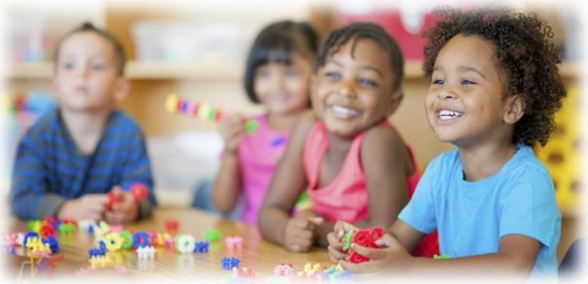
Name of church you attend _____

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: ____

____

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

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

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

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

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

8. Realizing tardies disrupt the class, embarrass the child, and cause him/her 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.

9. 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.

10. I know that the administration reserves the right to withdraw any student from Stepping Stones Preschool and Daycare 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: _____

Stepping Stones
PRESCHOOL

Dear Parents,

All students are required by the Maryland Department of Health and Mental Hygiene to have an updated shot record in the school office.
Since the 2014-2015 school year, immunization requirements in the state of Maryland have changed for the students entering kindergarten and Grade 7.

As a result, **ALL** students, who will be enrolling in school for the 2025-2026 school year, must receive two (2) doses of the Varicella (Chicken Pox) Vaccine.

The enclosed form must be used to get an updated shot record from your doctor. Please submit an updated shot record to the school office along with all other records that have been requested. A list of all the shot requirements for each age group is attached.

Students have twenty (20) calendar days after the start of the 2025-2026 school year to present medical verification of receiving the required vaccinations. In the event the documentation is not presented, the student will not be allowed in school until the required records have been provided.

Students will not be able to attend school unless updated records are turned into the office.

Your help in this matter is greatly appreciated.

Sincerely,

Melanie Stroud
Stepping Stones Director

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 physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations.*** *A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas.*** *The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their 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 provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

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

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

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:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any 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 (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

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

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

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.

_____ _____
Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

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

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. 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:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 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: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature:_____ Date: _____

5. 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).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ No	Test #1	Test#2	Test # 1	Test #2

_____ **has had a complete physical examination and any concerns have been noted above.**
(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

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

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

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

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

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

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

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

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

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

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

Comments:

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

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

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

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

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

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

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

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

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

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

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

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

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;

(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and

(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

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

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

2. _____
Signature Title Date

3. _____
Signature Title Date

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

Clinic / Office Name
Office Address/ Phone Number

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

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

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

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

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

Signed: _____ Date: _____

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child's Picture (Optional)

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions: _____

Medication shall be administered from: _____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Stepping Stones
PRESCHOOL

Dear Parents,

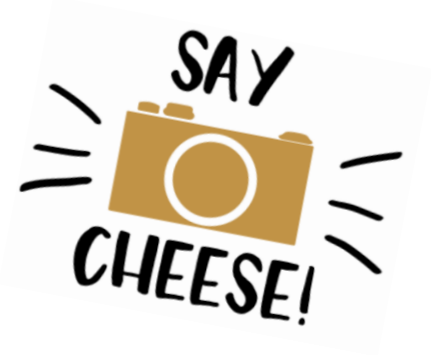
We are working hard to make our Preschool the best it can be! In doing so, we post pictures on Facebook and our website of fields trips and special events that we have in class.

We are requesting your permission to post your child's picture for Stepping Stones advertising purposes. Pease 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!

Mrs. Melanie Stroud
Stepping Stones Preschool Director



☐ 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

2025-2026 FINANCIAL SCHEDULE

Effective June 2025

REGISTRATION FEE- $200

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

TUITION- $825 per month
Additional siblings: $750 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 7:00 am-8:00 am each school morning

The Late Stay program runs from 3:30 pm- 6:00 pm each afternoon. The cost for these services is:

	Per Use:	Discounted Monthly Rate:
Early Stay:	**$8.00/hour**	**$125/month**
Late Stay:	**$8.00/hour**	**$250/month**

A late fee of $10.00 for the first five minutes and $1.00 per minute will be charged for each student not picked up 6:00 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

Stepping Stones
PRESCHOOL

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

Stepping Stones
PRESCHOOL

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 g 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

2025-2026 School Calendar

(dates subject to change)

August 2025

August 8	**Half Day**
August 11-15	**No School:** Teacher Training and Certifications
August 14	Parent Orientation
August 19	First Day of School

September 2025

September 1	**No School:** Labor Day
September 30	School Pictures
TBD	Grandparent's Day Breakfast

October 2025

October 24	**No School:** Annual Staff Training
October 30	Picture Retakes

November 2025

November 11	**No School**: Veteran's Day
November 25	Thanksgiving Lunch
November 26-28	**No School**: Thanksgiving Break

December 2025

December 19	Christmas Party – Noon Dismissal, No Late Stay
December 22-Jan 2	**No School**: Christmas Break

January 2026

January 5	**No School:** Teacher In-Service
January 6	School Resumes
January 19	**No School:** Martin Luther King Jr. Day

February 2026

February 16	**No School:** President's Day

March 2026

March 30-April 3	**No School:** Spring Break

April 2026

May 2026

May 1	Principal Appreciation Day
May 5	Teacher Appreciation Day
May 25	**No School**: Memorial Day
May 26-29	**No School:** Summer Teacher Work Week

June 2026

June 19	**No School:** Juneteeth

July 2026

July 3	**No School:** July 4th

FRENCH TOAST® SCHOOLBOX

French Toast Schoolbox is proud to partner with Independent Baptist Academy

Your web store is now open!

Check out the uniform options available for your student by going to:

FrenchToastSchoolbox.com

To begin shopping, select “Shop by School” and search by **Independent Baptist Academy or School Code: QS4T4S**

Your school will receive a 5% contribution on all qualified product purchases.

Orders $100 or more get free shipping!

Look for special savings in your web store – and sign up on our homepage to have coupon codes emailed to you.

Any questions?

Reach out to your dedicated French Toast Schoolbox Customer Service Team at 800-636-3104.

We look forward to serving you!