Welcome to Kindergarten
Deerfield Run Elementary School
13000 Laurel Bowie Road Laurel MD 20708
301-497-3610

Requirements needed to register:

➢ Child must be 5 years of age by September 1
➢ Parent’s picture ID
➢ Child’s original birth certificate with name of parent who is registering
➢ Child’s updated immunization record
➢ Proof of residence
   ▪ current lease that shows the name of the person registering student                  OR
   ▪ current deed to property or settlement papers with parent(s) name(s) and address
   AND
   ▪ two pieces of current mail
Prince George's County Public Schools
Prekindergarten Program

DEERFIELD RUN E.S.
13000 Laurel Bowie Rd.
Laurel, MD 20708
(301) 497-3610

When: Beginning April 2016

Time: 9:00 a.m. – 1:00 p.m.

Who is Eligible:
- Children must be 4 years of age by September 1
- Income eligible
- Children who reside within our attendance area

Must Bring:
➤ Parent’s ID
➤ Child’s original birth certificate
➤ Child’s updated immunization record
➤ Proof of residence (current lease or deed and 2 pieces of mail)
➤ Proof of income (two current pay stubs from everyone in the family, any eligibility forms or letters from Social Services, i.e., Food Stamps, Section 8, unemployment income documents, child support information, last year’s W-2 Tax Form-if currently self-employed)

Program Highlights:
* Half day Program
* Approved Early Childhood Curriculum
* 20 Children Per Class
* Certified Teacher and Paraprofessional Educator in each classroom
### MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>LAST /</th>
<th>FIRST /</th>
<th>MIDDLE /</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD'S ADDRESS</td>
<td>ADDRESS /</td>
<td>CITY /</td>
<td>STATE /</td>
</tr>
<tr>
<td>SEX: □ MALE □ FEMALE</td>
<td>BIRTHDATE / /</td>
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<tr>
<td>COUNTY /</td>
<td>SCHOOL /</td>
<td>GRADE /</td>
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<tr>
<td>PARENT OR GUARDIAN</td>
<td>LAST /</td>
<td>FIRST /</td>
<td>MIDDLE /</td>
</tr>
<tr>
<td>ADDRESS /</td>
<td>CITY /</td>
<td>STATE /</td>
<td>ZIP /</td>
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</table>

### CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.

2. Beginning not later than September 2003, the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.

3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.

4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

### RECORD OF BLOOD LEAD TESTING

<table>
<thead>
<tr>
<th>Test #1:</th>
<th>Date</th>
<th>Test #2:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
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</tbody>
</table>

Signature

Health Care Provider or Designee OR School Health Professional or Designee / Date

### RECORD OF BLOOD LEAD TESTING EXEMPTION

I, Parent or Guardian (Print) certify that my child does not AND has never resided in an at-risk area.

Signature

Parent or Guardian / Date

COMPLETETHE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

### RELIGIOUS OBJECTION:

1. 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. Signed Parent or Guardian / Date

2. Lead Risk Assessment Questionnaire Administered: YES □ NO □ Signed Health Care Provider / Date

DHMH #4620 Revised May 2004

Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health
410.767.6713
HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child’s primary health care provider may record the test dates directly on this form (check marks are not acceptable) 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. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

<table>
<thead>
<tr>
<th>Allegany</th>
<th>Baltimore Co. (Cont.)</th>
<th>Frederick. (Cont)</th>
<th>Montgomery (Cont)</th>
<th>Queen Anne's</th>
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Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate
http://www.fha.state.md.us/och/html/lead.html

DHMH #4620 Revised May 2004
410.767.6713
Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health
Deerfield Run Elementary School
Health Registration Information

The information provided on this form is necessary for the school nurse to contact someone in case of illness or emergency.

Please complete every section.

TODAY'S DATE ____________________ GRADE ________
STUDENT'S NAME
Last First Middle

DATE OF BIRTH ____________________ SEX ________ RACE ________
ADDRESS ____________________ STREET ________ APT# ________ CITY ________ ZIP CODE ________

HOME PHONE ____________________

PUPIL RESIDES WITH: MOTHER __, FATHER __, BOTH __
OTHER __ MAY WE CONTACT EITHER PARENT: ____________

FATHER'S NAME ____________________
HOME PHONE (IF DIFFERENT) ____________________ WORK PHONE ____________________ CELL/PAGER ____________________

MOTHER'S NAME ____________________
HOME PHONE (IF DIFFERENT) ____________________ WORK PHONE ____________________ CELL/PAGER ____________________

Has this child EVER ATTENDED a P.G. County School? ____________
Name of last P.G. County School ____________________

EMERGENCY CONTACT OTHER THAN PARENTS
NAME ____________________ PHONE ____________________

DOCTOR'S NAME ____________________ PHONE ____________________
FOOD ALLERGIES (please list) ____________________ , Epi-Pen ____________________

PLEASE INFORM THE SCHOOL NURSE AND CLASSROOM TEACHER IF YOUR CHILD HAS A FOOD OR BEE STING ALLERGY!

DOES YOUR CHILD HAVE ASTHMA ____________________

HEALTH CONCERNS ____________________

TAKE MEDICATION ____________________

BROTHER/SISTERS ATTENDING DEERFIELD ELEMENTARY? ____________________
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME ____________________________  LAST  FIRST  MI

SEX:  MALE ☐  FEMALE ☐

BIRTHDATE _____ / _____ / ________

COUNTY ___________  SCHOOL ___________  GRADE _____

PARENT NAME ____________________________

OR

GUARDIAN ADDRESS _______________________

CITY ___________  ZIP ___________

RECORD OF IMMUNIZATIONS  (See Notes On Other Side)

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Dose #</th>
<th>DTP-IPV-HIB</th>
<th>Polio</th>
<th>Hib</th>
<th>Hep B</th>
<th>PCV</th>
<th>Rotavirus</th>
<th>MCV</th>
<th>HPV</th>
<th>Dose #</th>
<th>Hep A</th>
<th>MMR</th>
<th>Varicella</th>
<th>History of Varicella Disease</th>
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</thead>
<tbody>
<tr>
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<td>DTP/Mo/yr</td>
<td>Polio</td>
<td>Hib</td>
<td>Hep B</td>
<td>PCV</td>
<td>Rotavirus</td>
<td>MCV</td>
<td>HPV</td>
<td>Dose #</td>
<td>Hep A</td>
<td>MMR</td>
<td>Varicella</td>
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<td>1st/yr</td>
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<td>12th</td>
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<td>11th</td>
<td>12th</td>
<td>Mo/yr</td>
</tr>
</tbody>
</table>

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.

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: ____________________________  Medical Provider / LHD Official  Date ____________

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: ____________

DHMH Form 896  
Rev. 2/14  
Center for Immunization  
www.dhmh.maryland.gov
PARENT INPUT CARD

TARJETA DE SUGERENCIA DE LOS PADRES

Help us by relating specific information about your child.
Please do not use this card to propose the following:
Teacher requests, grouping with friends, and/or separating
student from other students.

Ayúdenos proporcionando información específica acerca de su hijo.
Por favor, no use esta tarjeta para proponer lo siguiente: peticiones de maestros, la
agrupación de amigos y/o separar estudiante de otros estudiantes

Name of Student: ___________________________ Grade for 2016/2017: ____________
Nombre del estudiante: __________________ Grade para 2016/2017: ____________

Our child’s strengths: _______________________
Fortalezas de nuestro hijo/a _______________________

Area’s which need continued growth: ________________
Área donde necesita seguir creciendo ________________

Learning environment in which our child benefits the most: ______________________
Ambiente de aprendizaje que más le beneficiaría a nuestro hijo/a ______________________

Important things to know about our child: ______________________
Cosas importantes que debe saber acerca de nuestro hijo/a ______________________

Goals for our child to meet next school year: ______________________
Objetivos para nuestro hijo/a para el próximo año escolar ______________________

Other comments: ___________________________
Otros comentarios ___________________________

(Please see reverse side)
(Por favor vea el reverso)
LEARNING BEHAVIORS
CONDUCTAS DE APRENDIZAJE

Approaches to Learning: (Please check any behaviors that you feel would describe this child.)
Enfoques de Aprendizaje (Por favor marque cualquier comportamiento que usted sienta describe a su hijo/a)

___ shows eagerness about learning  muestra entusiasmo por aprender
___ attends to tasks  realiza las tareas
___ approaches tasks with flexibility  se enfoca en las tareas con flexibilidad
___ listens to others  escucha a otros
___ is respectful of others  es respetuoso/a con otros

___ shows curiosity about things  muestra curiosidad sobre las cosas
___ displays self-control  muestra auto control
___ responds to directions  responde a las direcciones
___ works cooperatively with others  trabaja en cooperación con otros
___ completes work independently  complete los trabajos independientemente

Social Preferences:
Preferencias Sociales:

___ playing alone/parallel play  jugando solo/juego paralelo
___ quiet activities (reading, listening, computer centers)  actividades tranquilas (lectura, escuchando, estación de computadora)
___ large motor activities (outdoor play, balls, large blocks)  actividades motoras grandes (juego aire libre, pelotas, cubos grandes)
___ small motor activities (puzzles, Legos, crafts, coloring)  grupos motores pequeños (rompecabezas, Legos, arte, colorear)

___ playing & interacting in small groups  jugando e interactuando en grupos pequeños
___ playing with one friend  jugando con un amigo
___ learning facts/information (science center)  aprendiendo datos/información (centro de ciencia)
___ activities involving pretending (dramatic play, puppets)  actividades de pretender (juego de drama, títeres)