



Lions and Lambs Summer Program Registration

Child's Full Name: _____

Address: _____

Child's Birthdate: _____

Age or Grade for 2026-2027 school year: _____

Mother Name: _____

Father Name: _____

Address: _____

Mother Cell: _____ Father Cell: _____

Mother Work: _____ Father Work: _____

Mother Email: _____

Father Email: _____

Allergies/Health Concerns:

FOR STAFF USE ONLY

Date of Registration _____

Military Discount _____

Registration Fee Submitted _____

Sibling Discount _____

Check# or online remittance _____

Early Registration _____



Lions and Lambs Summer Program Registration

Mark the weeks your child will attend Summer Programs.

\$40 per Family Registration Fee for the summer

\$250 per week for all day, \$140 per week for half day

**** (June 29-July 2 is \$200 for all day, \$115 for half day)**

Week	Date	Theme	Mark Weeks Attending	All Day 8am-3pm	Half Day 8am-11:30am
1	June 15 - 19	Ready, Set, Go			
2	June 22-26	Nature			
3	*June 29-July 2 4 day camp	Amazing Race			
4	July 6-10	Island Adventure			
5	July 13-17	Happy Holidays			
6	July 20-24	Splash Zone			
7	July 27-31	Carnival			
8	Aug 3-7	Kitchen Creations			
9	Aug 10-14	Under the Sea			

Mark Hours of Before and/or After care Needed

\$8.00 per hour - charged in 30 minute increments

	Monday Hours Needed	Tuesday Hours Needed	Wednesday Hours Needed	Thursday Hours Needed	Friday Hours Needed
Before Care Available Hours 7:00am-8:00am					
After care Available Hours 3:00pm - 5:00pm					

Summer Program Fees must be paid in full 30 days before your camp week starts



Medication Administration Permission Form

Student Name: _____

Grade _____ Date of Birth _____

Parent _____

Primary Phone Number _____

Secondary Phone Number _____

Medication Information

NOTE: All medications must be in the original container, clearly labeled with the student's name, the name of the drug, the dosage, and the frequency of administration. Prescription medications must have a current pharmacy label.

Medication Name _____

Dosage Instructions _____

Possible Side Effects _____

Physician Authorization (Required for all Prescription Medications)

Physician Name/Office (Please Print) _____

Physician Phone Number _____

Physician Signature _____

Parent/Guardian Permission and Acknowledgement

I give permission for the school personnel to administer the medication described above to my child according to the directions provided by the prescribing physician/manufacturer.

I hereby release the school district and all school employees and agents from any and all liability, claims, or causes of action arising from the administration of this medication, as prescribed, to my child.

Parent (please print) _____

Parent Signature _____

Date _____

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE _____/_____/_____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR
 GUARDIAN ADDRESS _____ CITY _____ ZIP _____

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	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
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
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	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4									
5	DOSE #5												

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

Clinic / Office Name
Office Address/ Phone Number

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: _____ 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: _____

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)

CAFCP Enrollment: Yes: ___ No: ___

Meals your child will receive while in care:

BK ___ LN ___ SU ___ AM Snk ___ PM Snk ___ Evng Snk ___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
 Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

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

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

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

Address _____
 Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES

 (Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

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

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Address _____
 Street/Apt. # City State Zip Code

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

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

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

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

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

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number