Child's last name:_____ first name_____

PBHS Documents for Pre-school Application

- Application
- Birth certificate or passport
- Parent agreement
    - Keep ONE copy for your records
- Food Restriction Sheet
- Pick-up Authorization form
    - Complete with phone numbers
- Photo Release Form
- MCPS ECD Program Procedures
- Immunizations (MDH Form 896, or computer form generated by physician/health clinic)
    - Must be submitted by the start of preschool in October, 2026
- MCPS Form SR-6 (Maryland Schools Record of Physical Examination
    - Must be submitted by the start of preschool in October, 2026

Office use only: Deposit rec'd: Amount: $ Cash☐ Check ☐ Check #

APPLICATION FOR ENROLLMENT 2026-2027

NAME OF PRESCHOOLER _____

FIRST Nickname LAST

BIRTH DATE (must be 3 ½ by 9/1/26)_____ BOY_____GIRL_____ NON-BINARY_____

MOTHER- *lives with? Yes*☐ *No*☐

FIRST LAST

ADDRESS _____

STREET CITY STATE ZIP CODE

PHONE_____ EMAIL _____

FATHER- *lives with? Yes*☐ *No*☐

FIRST LAST

PHONE_____ EMAIL_____

ADDRESS: _____

STREET CITY STATE ZIP CODE

LANGUAGE(S) SPOKEN AT HOME:_____

DOES YOUR CHILD SPEAK AND UNDERSTAND ENGLISH? _____

HOLIDAYS CELEBRATED: Please circle.

Christmas	Hanukkah	Kwanzaa	Diwali	Lunar New Year
Ramadan	Halloween	Thanksgiving	Rosh Hashanah	Yom Kippur
Eid al-Fitr				

SIBLINGS:

AGE: NAME: SCHOOL ATTENDING:

OTHER PRESCHOOL/DAYCARE/SUNDAY SCHOOL PROGRAMS YOUR CHILD HAS ATTENDED:

*****continued on next page*****

PLEASE INCLUDE INFORMATION ABOUT THE CHILD THAT WILL HELP THE TEACHERS GET TO KNOW THEM.

- Favorite food:
- Favorite movie/show:
- Favorite sport:
- What pets live with the child?
- What numbers do they know?
- What letters do they know?
- What colors do they know?
- What shapes do they know?

PLEASE NOTE:

- Parents will provide transportation to and from school.
  - Children must arrive on time and be picked up promptly.
  - If there are more than 3 late pick ups, the student may be removed from the program .
  - There will be no tuition reimbursement in this instance.
- The child must be between 3.5 years old by 9/1/26 and toilet trained to begin the program.
- Montgomery County School policy states that a child is eligible to attend the child development program for **only one year.**
- Health Inventory and Immunization Record must be completed before the child begins class.
- A **$100 non-refundable** deposit must be submitted with this application.
  - Deposits will be applied to the first semester tuition.
  - Make a check payable to Paint Branch High School.
  - Upon receipt of the application and deposit, the child's name will be placed on a waiting list pending acceptance.
- Tuition for the 2026-2027 school year will be **$450.00/semester**. Field trips fees may be additional.

PRESCHOOL PARENT AGREEMENT

I, (parent's name)_____, agree to adhere to the following criteria during the Paint Branch Child Development preschool program year 2025-26.

1. Be **on time** to drop off and pick up my child.
    - More than 3 late pickups may result in dismissal from the program **without** a tuition refund.
    - **Parents must initial here _____**
2. Respect the high school staff, and treat the students as teachers.
3. Be available for a parent orientation meeting, and other scheduled events.
4. Be willing to send snack items for holiday parties.
5. Take an active interest and participate in my child's preschool program.
6. Read all notes sent home or posted on the parent information board.
7. Provide a change of clothing to be kept at school for my child.
8. Pay fees and turn in all health forms before the first day of preschool.

If under any circumstances I cannot honor this commitment, I understand that I will no longer be able to keep my child (child's name) _____ in the Paint Branch Child Development program.

_____

Parent's Signature

_____

Date

Paint Branch High School
Child Development Program
14121 Old Columbia Pike
Burtonsville, MD 20866
(301)388-9948

Dear Parents,

You are responsible for informing us if your child has food restrictions due to allergies or family/religious practices. Please use the form below to provide us with this information. Please do not rely on verbal instructions.

Thank you for your cooperation.

Child's Name _____

____ Has no food restrictions

May not have the following food(s):

____ Dairy products

____ Eggs

____ Meat

____ Nuts

____ Peanuts

____ Raisins

____ Seafood

____ Other: Please specify _____

_____ _____
Parent Signature Date

CHILD PICK UP AUTHORIZATION

The following persons have my permission to pick up my child from the Child Development lab. I understand that a government issued ID will be requested of these individuals at time of pick up.

If your child is not picked up by 1:30, phone calls will be made to the list below, in order. More than 3 late pick ups may result in dismissal from the program.

CHILD'S NAME:

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

Name:	Cell:
Relationship to child:	

PB PRE-SCHOOL PHOTO RELEASE FORM

I, _____, the parent of a child at Paint Branch Pre-school child Development Lab, (hereinafter known as "PB Pre-school"), agree to the following:

I understand that my child (ren) whose name(s) are listed below may be photographed at the PB Pre-School during normal PB Pre-school hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print or on the Internet.

The child (ren) are known as: _____.

With my signature below I grant permission for my child (ren) to be photographed, or their images recorded for print or electronic use in promoting the PB Pre-School's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

Parent/Guardian Signature

_____

Date Relationship to Child

_____

Montgomery County Department of Health and Human Services Montgomery County Public Schools

TUBERCULOSIS PREVENTION/MANAGEMENT RECOMMENDATIONS

Dear Parent of_____Date _____

In an effort to keep our school children safe and healthy, the Montgomery County Department of Health and Human Services Tuberculosis Control Program recommends tuberculosis screening for all foreign-born students from any country other than the U.S as well as for all students, regardless of country of birth, who have lived outside the U.S. for 12 months or more prior to entry into the U.S.

The basis for this recommendation is that in Montgomery County, the incidence of tuberculosis (TB) is most prevalent in the foreign born population. Annually in Montgomery County, over 90% of tuberculosis cases are diagnosed in people born outside of the U.S.

In many foreign countries, BCG vaccine is given to prevent tuberculosis. Tuberculosis screening by skin test is not contraindicated for people who have been vaccinated with BCG.

Tuberculosis screening identifies infected students at risk of developing TB who would benefit from preventive therapy and also identifies students who need treatment for TB disease thus ensuring early intervention to prevent the spread of tuberculosis to others.

Students who are candidates for preventive therapy or for treatment of tuberculosis will receive complete case management and treatment by the TB Control Program staff in collaboration with the School Health Services staff at no cost to their families.

Evidence of freedom from active tuberculosis disease consists of **one** of the following:

- Documentation of a negative TB test.
- Documentation of a positive TB test, a negative chest x-ray and no symptoms of tuberculosis.
- Documentation of adequate treatment of tuberculosis and no symptoms of tuberculosis.

If your child was born in a foreign country, lived outside the U.S. for 12 months or more, or has been exposed to someone with active TB, please have your child's health care provider provide the recommended tuberculosis testing and documentation. Testing and documentation may also be obtained at the locations listed on the back of this letter. If you have any questions please contact the school nurse at_____.

Sincerely,

_____ _____

Principal School Nurse

(over)

Montgomery County Resources for Tuberculosis Screening and Testing:

TB skin tests are administered on the first visit and then read 2 – 3 days (48 – 72 hours) later.
TB blood tests do not require a return visit.

TB screening (PPD skin tests only)

School Health Services Immunization Center
4910 Macon Road, Rockville, MD 20852
240-740-4430
Monday, Wednesday, Friday 8:30 am to 11:30 am

Additional TB Testing (QuantiFERON® TB blood test, Chest X-ray, Medical Evaluation)

TB Control Program, Dennis Avenue Health Center
2000 Dennis Avenue, Silver Spring, MD 20902
240-777-1800 Call between 8 am and 4 pm to make an appointment
Monday through Friday by appointment only

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-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	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 #4	DOSE #9
5	DOSE #5			DOSE #5					_____		_____	_____	DOSE #5	DOSE #10

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: _____

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)

Student Record Card 6

Maryland State Department of Education (MSDE)
Maryland Department of Health (MDH)
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
Rockville, Maryland

MARYLAND SCHOOLS RECORD OF PHYSICAL EXAMINATION

To Parents or Guardians:

In order for your child to enter a Maryland public school for the first time, the following are **required:**

- **A physical examination by an authorized health care provider must be completed within nine months prior to entering the public school system or within six months after entering the system.** A physical examination form designated by the Maryland State Department of Education and the Maryland Department of Health must be used to meet this requirement.
- **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.** A Maryland Immunization Certification form for newly enrolling students may be obtained from the local Department of Health and Human Services or from school personnel. The form and the required immunizations must be completed before a child may attend school. (Form MDH 896).
- **Evidence of blood lead testing is required for all students who reside in a designated at risk area or who are enrolled in Medicaid when first entering Prekindergarten, Kindergarten, and Grade 1, and for ALL children born on or after January 1, 2015.** The Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (DHMH 4620) (or another written document signed by an authorized health care provider) shall be used to meet this requirement.

Exemptions from immunizations are permitted if they are contrary to a student's or family's religious beliefs, and require parent/guardian signature on MDH Form 896. Students also may be exempted from immunization requirements if an authorized health care provider certifies that there is a medical reason not to receive a vaccine. Exemptions from blood lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood Lead Testing Certificate must be signed by an authorized health care provider stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

In order to assist your child in gaining the most from their educational experience, please complete Part I of this Physical Examination form. Part II must be completed by an authorized health care provider, or attach a copy of your child's physical examination to this form. If your child requires medication and or a treatment to be administered in school, you must have the authorized health care provider complete a medication and or treatment administration form for each medication and or treatment to be administered. These forms can be obtained from your child's school or online from the Montgomery County Public Schools (MCPS) website at *www.montgomeryschoolsmd.org*: MCPS Form 525-12, *Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement*, MCPS Form 525-13, *Authorization to Administer Prescribed Medication, Release and Indemnification Agreement,* MCPS Form 525-14, *Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector*. If you do not have access to an authorized health care provider or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.

Please complete this Physical Examination form and return it to your child's school as quickly as possible.

PART 1 HEALTH ASSESSMENT **To be completed by parent/guardian**			MCPS ID#
Student's Name (Last, First, Middle) (Preferred Name)	Birthdate (Mo., Day, Yr.)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.
Parent/Guardian Names			
Where do you usually take your child for routine medical care? Name: Address:			Phone No.
When was the last time your child had a physical exam? Month Year			
When was the last time your child had a dental exam? Month Year			
Where do you usually take your child for dental care? Name: Address:			Phone No.

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any of the following? Please check yes or no below.

	Yes	No	Comments
Anaphylaxis or severe allergic reactions			
Allergies (Food, Insects, Medications, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavioral or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental Problems			
Diabetes			
Ear Problem or Deafness			
Eating Problems			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication? ☐ No ☐ Yes

If yes, name(s) of medications: _____

Will your child require any medication to be administered in school? ☐ No ☐ Yes

If yes, name(s) of medications: _____

Will your child require any emergency medications (epinephrine auto-injectors, inhalers, glucagon, Diastat, nebulized medication, etc.) to be administered in school? ☐ No ☐ Yes If yes, please list _____

Will your child require any special treatments (G-tube feedings, catheterizations, etc.) to be administered in school? ☐ No ☐ Yes

If yes, please list _____

I agree that by typing my name and today's date below, and submitting this form by electronic mail, I am intending that the below constitutes and is the equivalent to my personal signature.

Parent/Guardian Signature Date

PART II SCHOOL HEALTH ASSESSMENT
To be completed ONLY by authorized health care provider

MCPS ID#

Student's Name (Last, First, Middle) (Preferred Name)	Birthdate (Mo., Day, Yr.)	Name of School	Grade

1. Does the child have a diagnosed medical condition? ☐ No ☐ Yes

   Specify _____

2. Does the child have a health condition which may require EMERGENCY ACTION while at school? (e.g., seizure, severe allergic reaction/anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please work with the school nurse to develop an emergency plan. ☐ No ☐ Yes

   Specify _____

3. Are there any abnormal findings on evaluation of concern? ☐ No ☐ Yes

   Specify _____

EVALUATION FINDINGS/CONCERNS

PHYSICAL EXAM	WNL	ABNL	Area of Concern	HEALTH AREA OF CONCERN	Yes	No
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings/health concerns.)

4. **RECORD OF IMMUNIZATIONS**: MDH 896 is required to be completed and attached by an authorized health care provider ***or*** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. ☐ No ☐ Yes

   _____

   (*MCPS Form 525-13, *Authorization to Administer Prescribed Medication, Release and Indemnification Agreement and/or MCPS Form 525-14, Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector, must be completed for medication administration in school).

6. Will the child require medically provided treatments, such as urinary catheterization, tracheostomy, gastrostomy feedings, and oral suctioning? ☐ No ☐ Yes If yes, MCPS Form 525-12, *Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement*, must be completed.

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. ☐ No ☐ Yes
   MCPS Form 345-22 may be completed.

   _____

   _____

PART II SCHOOL HEALTH ASSESSMENT *(continued)*
To be completed ONLY by authorized health care provider

8. **Screenings**	**Results/Date Taken**	**Comments**
Tuberculin Test (PPD, QFT, Questionnaire)		
Blood Pressure/Heart Rate		
Height		
Weight		
BMI %tile		
Blood Lead Testing (DHMH 4620)		
Hemoglobin/Hematocrit		

(Student Name) _____ has had a complete physical examination and has:

☐ No evident problem that may affect learning or full school participation ☐ Problems noted above

Additional Comments:

Name of Authorized Health Care Provider (Type or Print)	Phone No.	Authorized Health Care Provider Signature	Date