AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

MEDICATION TYPE:

PRESCRIPTION/ NON-PRESCRIPTION/ TOPICAL OINTMENT

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Playful Minds Academy agents to administer the following medication to my child:

Child's Name:

_____

•**Prescription Medications:** must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.

•**Non-prescription Children's Medication:** can be administered for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent/guardian Written authorization from the child's medical provider is required to continue use beyond the three consecutive days.

•**Non-prescription Topical Children's Ointments:** can be applied with authorization from the parent/guardian according to the manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.

•**Non-prescription Topical Children's Ointments:** can be applied to **open, oozing sores** for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent/guardian. This includes diaper cream, sunscreen, insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children. Written authorization from the child's medical provider is required to continue use beyond the three consecutive days or if the condition worsens.

•**As Needed Children's Medications:** require written authorization from the child's medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.

•**Medications for Chronic Illnesses**: require a written order from the child's medical provider for a period not to exceed ***one year***. (See Prescription and Non-prescription medication above for details)

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Playful Minds Academy LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Six Rights of Medication

1.Verification that the *right* child receives

2.The *right* medication

3.In the *right* dose

4.At the *right* time

5.By the *right* method

6.*And the right* documentation is completed

Medication: _____

Administration Route: _____

Reason for Medication: _____

Medication Storage: _____

Side Effects:

_____

__

_____
_____

Dosage:

_____
_____

Times of Administration: _____ _____ _____
_____

Start Date: _____
End Date: _____

Physician's Name: _____
Physician's License Number: _____

Physician's Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST) (FIRST)

PARENT/GUARDIAN:

DATE OF BIRTH: HOME PHONE:

ADDRESS:

CHILD CARE FACILITY NAME:

FACILITY PHONE: COUNTY:

WORK PHONE:

I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE: _____

Parents may write immunization dates; health professional should verify and complete all data. **DO NOT OMIT ANY INFORMATION**! This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. (If NONE please print N/A):

CHILD'S ALLERGIES (DESCRIBE, IF ANY):

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? † YES † NO

IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) † YES † NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3):

HEARING (subjective until age 4):

LEAD:

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS

Immunizations	*Date*	*Date*	*Date*	*Date*	*Date*	*Date*
HEP- B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						
COMMENTS:						

MEDICAL CARE PROVIDER:
ADDRESS:
PHONE:
SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
TITLE: _____

LICENSE NUMBER: DATE FORM SIGNED: _____

CHILD'S INFORMATION

Child's Name: _____
Primary Language: _____

Child's Address:

_____

Street City/Town Zip Code

Place of Birth: _____
Date of Birth: _____/_____/_____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name: _____
Name: _____

Relationship: _____
Relationship: _____

Address: _____
_____

Address: _____
_____

Home E-mail Address: _____
Home E-mail Address: _____

Cell Phone: _____
Cell Phone: _____

Home Phone: _____
Home Phone: _____

Others in Family Relationship:

_____

Parent/Guardian Business Information

Company Name: _____
Company Name: _____

Address: _____

_____

Address: _____

_____

Business Phone: _____
Business Phone: _____

E-mail Address: _____
E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Race: _____ Gender ☐ M ☐F

Identified Allergies:

_____

Identifying Marks:

_____

Health Insurance Provider:

_____

Physician/Dentist Information

Name of Physician/Clinic: _____
Phone: _____

Physician Address/ Street City/Town Zip Code

_____

Date of Child's Last Physical: _____

Name of Dentist: _____
Phone: _____

Dentist Address:

_____

Street City/Town Zip Code

Parent/Guardian Signature: _____
Date: _____

FOR CENTER USE: Center: _____ Date of Admission_____
Age of Admission: _____

Director's Initials: _____

Informed Consent

Child's Name:_____

ACCESS

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

CHILD RELEASE

For a child's safety, Bright Horizons will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order.

Third party pick-up is subject to the following rules:

At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.

If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.

If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**.

Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

NAME_____

ADDRESS_____

CITY/TOWN/STATE/ZIP_____

RELATIONSHIP TO CHILD_____

DAYTIME PHONE CELL PHONE_____

E-MAIL_____

CONTACT IN THE EVENT OF AN EMERGENCY? YES NO

NAME_____

ADDRESS_____

CITY/TOWN/STATE/ZIP_____

RELATIONSHIP TO CHILD_____

DAYTIME PHONE CELL PHONE_____

E-MAIL_____

CONTACT IN THE EVENT OF AN EMERGENCY? YES NO

NAME_____

ADDRESS_____

CITY/TOWN/STATE/ZIP_____

RELATIONSHIP TO CHILD_____

DAYTIME PHONE CELL PHONE_____

E-MAIL_____

CONTACT IN THE EVENT OF AN EMERGENCY? YES NO

Playful Minds Academy will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

WALK PERMISSION

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises. I give permission for my child to participate in walks. Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

PARENT/GUARDIAN INITIALS: _____

PHOTOGRAPHY & VIDEO PERMISSION

Playful Minds Academy regularly takes photographs and videos of children enrolled for its business purposes. Playful Minds Academy retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. They may be shared with you and other families on a Playful Minds Academy website, by e-mail, by posting in the center, or in a parent newsletter. They may be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. They may be used for other center, general business, and marketing purposes, including online. Playful Minds Academy takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. I give permission for Playful Minds Academy to take photographs and videos of my child and use these materials for its business purposes.

CHILD ILLNESS

If my child becomes ill, I will be called. I may be required to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care.

CHILDREN'S INJURIES

If my child sustains a minor injury during care, I will receive an Occurrence Report when I pick-up describing the incident.

I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

EMERGENCY MEDICAL CARE

If emergency medical attention is needed for my child, the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Playful Minds Academy to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to my preferred facility, if possible. Staff is trained in CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

CHILD'S HEALTH INSURANCE PROVIDER

NAME OF INSURED_____

POLICY NUMBER_____

FAMILY GUIDE ACKNOWLEDGEMENT

By signing below, I acknowledge and agree that: 1) I received this Informed Consent, 2) It is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

Parent/Guardian Signature_____

Date_____

Parent/Guardian Signature_____

Date_____

Annual parent/guardian review and signature is required by Playful Minds Academy
and some state licensing agencies. If any changes are necessary, a new form will be completed.

PARENT/GUARDIAN SIGNATURE REVIEW
DATE_____

PARENT/GUARDIAN SIGNATURE REVIEW
DATE_____

PARENT/GUARDIAN SIGNATURE REVIEW
DATE_____

PARENT/GUARDIAN INFORMATION FORM

There may be times phone numbers and addresses of families are requested by parents/ guardians so that children may have "play dates" outside of the center/school.

Please check the information that Playful Minds Academy **MAY** give to other parents/guardians enrolled in the center/school upon request.

Child's Name: _____

1. Parent/Guardian Name:
   _____

Parent/Guardian Home Phone Number _____

Parent/Guardian Work Phone Number _____

Parent/Guardian Cell Phone Number_____

Parent/Guardian Home Address _____

Parent/Guardian E-mail Address _____

2. Parent/Guardian Name:
   _____

Parent/Guardian Home Phone Number _____

Parent/Guardian Work Phone Number _____

Parent/Guardian Cell Phone Number _____

Parent/Guardian Home Address _____

Parent/Guardian E-mail Address _____

Please do not give out any of the information listed above.
The information detailed above will be shared only with parents/guardians whose children are currently enrolled in the center/school.

Parent/Guardian signature: _____

Date: _____

Suspected Allergy/Food Intolerance Form

This form is to be completed by the parent/guardian when the parent/guardian suspects their child may be allergic to a product or has a food intolerance; however, has not received a medical diagnosis or a health care plan from the child's medical provider.
Note: If the suspect allergy or food intolerance is medically diagnosed, a Health Care Plan completed and signed by the child's medical provider is required (Provided by the center)
Child's Name: _____ Child's Date of Birth_____
My child has a ☐ suspected allergy ☐ food intolerance to:

_____ _____
_____ _____
_____ _____
I suspect /am concerned my child may be allergic for the following reasons:
No previous exposure Family history
Previous reaction (please explain/date of reaction): _____
_____
_____
Other: _____
_____
_____ _____
Parent/Guardian Signature Date
This form must be updated annually or whenever there is any change in treatment or the child's condition changes.
To eliminate the suspected allergy or food intolerance and allow your child to eat the suspected item(s) while at Playful Minds Academy, please complete the following.
I _____, acknowledge that my child no longer has a suspected allergy to _____ and may now be served this item(s) while at Playful Minds Academy
Parent/Guardian signature: _____

Date: _____

Allergy Health Care Plan

Child's Name: _____
DOB: _____
Parent/Guardian Name: _____
Phone: _____
Physician's Name: _____
Phone: _____
Allergen Treatment/Substitution

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Type of allergy transmission: *☐ Ingestion ☐ Contact ☐ Inhalation*
Note: Do Not Depend on Antihistamines or Inhalers to treat a severe reaction. USE EPINEPHRINE.
Extremely Reactive to the Following
Foods_____;
therefore:

☐ ***If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.***
☐ ***If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.***

For the following signs of a mild allergic reaction administer:

_____
_____
_____

☐ ***Skin:*** *Hives: Mild Itch*
☐ ***Nose:*** *Itchy, Runny, Sneezing*
☐ ***Stomach:*** *Mild Nausea/Discomfort*
☐ ***Mouth:*** *Itchy*
☐ ***Other:***

_____

For any of the following signs of a severe allergic reaction or a combination of symptoms from different body areas, give Epinephrine and call 911. If prescribed and directed, give other medications

(antihistamine/inhaler). Lay person flat. If breathing is difficult or vomiting, place on side, or sit up.

☐ ***Mouth:*** *Significant Swelling of Tongue and/or Lips*
☐ ***Heart****: Pale, blue, faint, weak pulse, dizzy*
☐ ***Throat:*** *Tight, hoarse, trouble breathing/swallowing*
☐ ***Lungs:*** *Short of Breath*
☐ ***Skin:*** *Many hives over body, widespread redness*
☐ ***Stomach:*** *Repetitive vomiting, severe diarrhea*
☐ ***Other:*** *Feeling something bad is about to happen; anxiety, confusion*

Other Medication Instructions:

_____
_____
_____

This form is required for any child who has mild to severe allergies and must be completed by the child's parent/guardian and the child's physician.

Prescribed Medications/Dosage:
Epinephrine (brand and dose):

_____
Antihistamine (brand and dose):

_____
Other (e.g., inhaler-bronchodilator if asthmatic):

_____
Potential Side Effects of Medication:

_____
_____
Potential Consequences to Child if Treatment is Not Administered:

_____
_____

Physician Signature: _____
Date: _____
Director _____
Date: _____

Parent/Guardian Acknowledgement Statement
To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s); or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Playful Minds Academy requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen on the Allergy Awareness Chart.

Parent/Guardian Signature: _____

Date: _____

*****For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Authorization for Administration of Medication* form.

This plan must be updated annually or whenever there is any change in treatment