

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ Birth Date: _____

Address: _____

Mother / Legal Guardian's Name: _____ Home Number: _____

Address: _____ Cell Number: _____

Work Address: _____ Work Number: _____

Father / Legal Guardian's Name: _____ Home Number: _____

Address: _____ Cell Number: _____

Work Address: _____ Work Number: _____

Emergency Contact Person: _____ Contact Number: _____

Emergency Contact Person: _____ Contact Number: _____

Physician / Medical Care Source: _____ Contact Number: _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ Name: _____

Name: _____ Name: _____

**NON-INGESTIBLE
OVER THE COUNTER (OTC) MEDICATION
AUTHORIZATION FORM**

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____/____/____
Program Name _____ Today's Date ____/____/____

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

- ☐ Diaper Rash Cream/Ointments
- ☐ Insect Repellent
- ☐ Sunscreen
- ☐ Cortisone/Anti-Itch Creams/Ointments
- ☐ Medicated Lip Treatments
- ☐ OTC Antibiotic Creams/Ointments
- ☐ Burn Creams/Sprays
- ☐ Other Non-Ingestible OTC's: (Please Specify) _____
- ☐ _____
- ☐ _____
- ☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions _____ Refrigeration Y/N

*** Parent/Guardian Signature (required)** _____ *** DATE:** _____

*** This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date ____/____/____

***Keep in the child's file when medication is finished.**