Enrollment Forms Checklist

- Application form
- Evacuation Procedures
- Disaster Release Form
- Notification of Parent's Rights LIC 995
- Parent's Rights Information LIC 995E
- Personal Rights LIC 613A
- Physician's Report LIC 701
- Preadmission Health History LIC 702
- Identification and Emergency Information LIC 700
- Sunscreen Release
- Field Trip/Medical Consent
- Parent Handbook
- Parent Handbook Acknowledgement
- Parent Information About Inhaled Medication Procedures
- Inhaled Medication Authorization
- Parent Information About Epinephrine Procedures
- Epinephrine Authorization
- Photo Release

EVACUATION PROCEDURES

Center	Primary Site	Secondary Site
Little Wings of Atascadero Preschool	Atascadero Lake Park Lago avenue	Heilmann Regional Park 9400 el Bordo Ave

In the event of an emergency or disaster involving the center, the following procedures will be implemented:

1. The telephone will be used for <u>outgoing emergency calls only</u> and will be kept off the hook the remainder of the time.

2. Children will remain on the premises or at the designated emergency evacuation site for 72 hours unless released to an emergency medical facility or appropriate civil authorities. (See above evacuation sites for information.)

3. Children unclaimed after 72 hours will be released to appropriate civil authority (i.e., Red Cross, police, fire department facility, National Guard, etc.). If appropriate civil authority is not available, center staff will determine the best action for the safety of the children. The decided action and destination of the children will be posted at the center and at the designated evacuation site.

4. Signs will be clearly posted at centers giving destination of evacuated children.

5. Appropriate news media will be informed of the evacuation so information may be broadcast and printed.

6. There will be a specific area for claiming and signing out children at the evacuation site. ***Only adults <u>previously authorized</u> on the emergency cards will be able to sign out children.***

Little Wings is required to have on hand a 72-hour supply of food, water, sanitation and medical supplies. Staff are required to remain with the children until they are claimed by their families or released after 72 hours to a proper civil authority. Parents/guardians claiming children may be asked to stay and assist in caring for unclaimed children until additional help arrives. Please plan ahead with friends and family to facilitate the most effective emergency response (all authorized pick-ups should be aware).

At the time of enrollment, children must have the following items:

- A 72-hour supply of appropriate food for children with dietary restrictions.
- All necessary disaster medical forms completed.
- Any emergency equipment/medication/instructions necessary for your child packed appropriately with disaster supplies.
- All parents of infants/toddlers must provide a three-day supply of diapers and ready-to-use formula.

EARTHQUAKE / DISASTER / EMERGENCY
IDENTIFICATION AND RELEASE

Child's Name		Enrollment Date
Medical concerns or allergies		
Parent/Guardian Name		
Home Address	City	ZIP
Parent/Guardian Phone Number		Parent/Guardian Phone Number
Out-of-State Contact Name & Phone		
Authorized emergency pick-up names and phone numbers: 1)		
2)		
3)		
Special instructions or message for your child and teacher(s):		

Attach below a current photo of your child for identification purposes.

-ATTACH PHOTO HERE-

THIS FORM TO BE LAMINATED AND PLACED WITH EMERGENCY SUPPLIES

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Dept. of Social Services, Community Care Licensing Division

   Licensing Office Address: 6500 Hollister Ave, SUITE 200 Goleta, CA 93117

   Licensing Office Telephone #: (805)562-0400

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccl.dss.cahwnet.gov/RegionalOf_1829.htm**

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Department of Social Services, Community Care Licensing Division

ADDRESS

6500 Hollister Ave, Suite 200

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Goleta	93117	805-562-0400

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE ZIP		BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

Permission to Apply Sunscreen

Little Wings
A PRESCHOOL FOR EVERYONE

Name of Child: _____

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for the staff at:

_____

(name of child care program)

to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he/she will be playing outside, especially during the months of March through October and between the daily time of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have *checked* and *initialed* below **all** applicable information regarding the child care program's choice in brand/type and use of sunscreen for my child.

Please note that for summer school-age programs parents are asked to supply sunscreen for application for their child(ren).

Please check below all information that applies to your child:

☐ I do not know of any allergies my child has to sunscreen.

☐ My child is allergic to some sunscreens. I will provide my child's sunscreen.
☐ Staff may use the sunscreen o the program's choice following the directions and recommendations printed on the product container.

☐ For medical or other reasons, please do NOT apply sunscreen to the following areas of my child's body: _____
_____

Parent/Guardian's Name: _____ **Date:** _____

Parent/Guardian's Signature: _____

NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!

FIELD TRIP PERMISSION

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The program that we have planned may involve field trips — sometimes within walking distance, sometimes via car. We will keep you informed of our planned field trips. However, some trips will be spontaneous. The center carries insurance to cover these activities. In order for your child to participate, we need your written permission.

I give my permission for my child,

First Name (Please Print)	Last Name

to participate in the field trips planned by the center, either by walking, private automobile, chartered bus, or by public transportation.

Parent/Guardian name	
Parent/Guardian Signature	Date

7/09

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CONSENT FOR EMERGENCY MEDICAL TREATMENT – Child Care Centers or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Little Wings of Atascadero Preschool

TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.), OR DENTIST (D.D.S.) FOR

First Name (Please Print)	Last Name

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

Parent or Authorized Representative Signature		Date
HOME ADDRESS	CITY	ZIP
HOME PHONE ( )		MOBILE PHONE ( )

Parent Handbook Acknowledgement

The Parent Handbook can be found on little Wings website, www.littlewingsofatascadero.com, in the Parent Resources Tab.

Please read the handbook, then sign and return this form to your center director/site supervisor along with your other enrollment forms.

I have read and understand all of the policies included in the Parent Handbook and agree to follow them.

I understand that failure to follow these policies may lead to termination of child care services.

_____

Print Parent Name

_____ _____

Parent Signature Date

Little Wings
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PARENT INFORMATION ABOUT INHALED MEDICATION PROCEDURES

Medications prescribed for a child to control lung-related illness, including but not limited to, local held nebulizers, may be administered by Little Wings staff. Specific instructions from parent/legal guardian and child's physician must be provided.

1. The Inhaled Medication Authorization Form must be completed and signed by the child's parent and physician.
2. The form must be on file at the center. The parent is responsible for obtaining the physician's statement in Part II.
3. A new form must be submitted to the center each year AND whenever there is a change in the dosage or a change in the conditions under which inhaled medications are to be administered.
4. A physician may use office stationery or a prescription pad in lieu of completing Part II. Necessary information includes:
    a. Name of child
    b. Reason for medication or diagnosis
    c. Name and exact dosage of medication
    d. Time(s) for medication and frequency or exact time interval dosage is to be administered
    e. If medication is given on an 'as needed' basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again
    f. Duration of medication order and effective dates
    g. Possible adverse reactions
    h. Physician signature, address
    i. Date
5. Medication must be properly labeled by a pharmacist. Expiration date must be clearly indicated.
6. Inhaled medications must be hand-delivered to the center by the parent.
7. Parent is to collect any unused medication upon expiration date of the medication or expiration of the order or on the last day of school (school age programs only).

INHALED MEDICATION AUTHORIZATION

Part I Parent or Guardian to Complete

I hereby authorize the child care staff to administer inhaled medications as directed by the physician (Part II). I agree to release, indemnify, and hold harmless Little Wings and any of their staff members, or directors from lawsuits, claims, expense, demands, or actions, etc. against them for administering inhaled medications. I have read the procedures attached to this form and assume responsibility as required.

I authorize the child care staff to contact my child's physician for more information related to this medication.

Name of Child

Date of Birth | Center

Has the child taken this medication before? ☐ Yes ☐ No

First dose must be given at home to ensure the child does not have an adverse reaction.

Parent/Guardian Name | Parent/Guardian Signature

Date of Authorization

Part II Child's Physician to Complete (use other side as necessary)

Name of Medication | Dosage

Date medication administration begins | Date medication ends (if known)

Diagnosis

Triggers

Symptoms or activity for which medication is ordered

Time(s) medication is given

Time interval for repeating dose

If child is taking more than one medication, list sequence in which medications are to be taken.

Potential side effects

Action to be taken in the event of side effects or incomplete treatment

Storage of medication: | Safety precautions:

Physician's Name | Telephone

Physician's address

Physician's Signature | Date

Part III Child Care Director to Complete

☐ Parts I and II above are complete and include signatures. (It is appropriate if all items in Part II are written on physician's stationery or prescription pad.)

☐ Medication is appropriately labeled.

Date of medication expiration. Parent must collect expired medication immediately upon expiration.

Director Signature | Date

Form must be updated annually. 2019

PARENT INFORMATION ABOUT EPINEPHRINE PROCEDURES

Medications prescribed for a child in the event of an allergic emergency may be administered by Little Wings child care staff. Specific instructions from parent/legal guardian and child's physician must be provided.

1. Only premeasured doses of epinephrine may be administered.
2. The Epinephrine Authorization Form must be completed and signed by the child's parent and physician.
3. The form must be on file at the center. The parent is responsible for obtaining the physician's statement in Part II.
4. A new form must be submitted to the center each year AND whenever there is a change in the dosage or a change in the conditions under which epinephrine is to be injected.
5. A physician may use office stationery or a prescription pad in lieu of completing Part II. Necessary information includes:
    a. Name of child
    b. Specific allergen for which epinephrine is being prescribed
    c. Route of exposure (e.g., ingestion, skin contact, inhalation, or insect sting or bite)
    d. Brand name of medication
    e. Amount of premeasured epinephrine
    f. Duration of medication order and effective dates
    g. Possible adverse reactions
    h. Other necessary information
    i. Physician signature
    j. Date
6. Medication must be properly labeled by a pharmacist. Expiration date must be clearly indicated.
7. Epinephrine must be hand-delivered to the center by the parent.
8. 911 and the child's parent will always be called when epinephrine is administered, whether or not the child manifests any symptoms of anaphylaxis.
9. Parent is to collect any unused epinephrine upon expiration date of the medication or expiration of the order or on the last day of school (school age programs only).

EPINEPHRINE AUTHORIZATION

Part I Parent or Guardian to Complete

I hereby authorize the child care staff to administer epinephrine injection(s) as directed by the physician (Part II). I agree to release, indemnify, and hold harmless little Wings and any of their staff members, or directors from lawsuits, claims, expense, demands, or actions, etc. against them for administering injection. I am aware that the injection may be administered by a specifically trained non health professional. I have read the procedures attached to this form and assume responsibility as required.

I understand that emergency medical services (EMS) and parent will always be called when epinephrine is given, whether or not my child manifests any symptoms of anaphylaxis.

Name of Child

Date of Birth | Center

Parent/Guardian Signature

Parent/Guardian Name

Date of Authorization

Part II Child's Physician to Complete

Emergency injections are administered by nonhealth professionals. For this reason, only premeasured doses of epinephrine may be given. It should be noted that staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

Name and Dosage of Medication

Date medication administration begins | Date medication ends (if known)

~~The above named injection will be given immediately after report of exposure to (indicate specific allergens):~~

Route of exposure: (circle all that apply) ingestion skin contact inhalation insect sting or bite

Other:

Possible adverse reactions

Other helpful information for child care staff (use back of sheet if necessary)

Physician's Name | Telephone

Physician's Signature | Date

Part III Child Care Director to Complete

☐ Parts I and II above are complete and include signatures. (It is appropriate if all items in Part II are written on physician's stationery or prescription pad.)

☐ Medication is appropriately labeled.

Date of medication expiration. Parent must collect expired medication immediately upon expiration.

Director Signature

Date

Form must be updated annually.

January 2019

PHOTO RELEASE

Little Wings
A PRESCHOOL FOR EVERYONE

On occasion, Little Wings staff and therapist will take photographs of enrolled children. These photos are primarily used for center purposes: to display in the center to show parents what the children have been involved in or to create keepsakes for the staff or children of their experiences as well as for use in therapy sessions. Occasionally we find the need to use a photo for marketing purposes: LW newsletter, LW website, summer brochure, local newspaper advertising.

We can only use your child's photo if we have permission from you. Please indicate below if you do or do not authorize the use of photos of your child for purposes other than center-based needs.

PLEASE NOTE - Children's names will not be used without prior written parent consent.

☐ Yes, I authorize Little Wings to use photos of my child for the below purposes:

Check all that apply

A ☐ ALL (Listed Below)

B ☐ Center Newsletter
C ☐ Little Wings Marketing Materials, ex. Newsletter, brochure, Annual Report
D ☐ Little Wings Website
E ☐ Little Wings Social Media, ex. Facebook page
F ☐ Local Advertising, ex. local newspaper, summer brochure

☐ No, I do not authorize Little Wings to use photos of my child for marketing purposes.

_____
Child's Name (please print)

_____
Parent/Guardian's Name (please print)

_____ _____
Parent/Guardian's Signature Date

Little Wings PRESCHOOL

himama

HiMama is our school's App that allows you to receive Daily Reports with Photos/Videos of your child's day, send and receive direct messages with Teachers, pay tuition, etc. Once we've entered the following information internally, you'll receive an email prompting you to download the HiMama App!

Child Information

Child's Full Name: _____ Date of Birth: _____

Child's Address: _____

Permitted in photos and Videos with other Children (Please Circle): Yes No

Enrollment

Please Circle One of the Following: Mornings OR Full Day

Schedule (Circle Days Child Will Attend) M T W Th F

Contacts

Parent/Guardian #1 Name (First and Last): _____

Email: _____ Phone: _____

Phone 2: _____ Relationship (Please Circle): Parent Or Guardian

Parent/Guardian #2 Name (First and Last): _____

Email: _____ Phone: _____

Phone 2: _____ Relationship (Please Circle): Parent Or Guardian

Emergency Points of Contact

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____