FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Consent Form 102 CMR 7.09(3)

Child's Name _____Date of Birth _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment to my child.

Child's Physician Name _____Phone number: _____

Address _____ City_____

Child's Allergies _____

Chronic Health Conditions _____

(if none please indicate none)

Emergency Contacts (in order to be contacted)

Name: _____ Address: _____

Relationship to Child: _____ Reachable Phone # _____Cell Phone # _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Address: _____

Relationship to Child: _____ Reachable Phone # _____Cell Phone # _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Address: _____

Relationship to Child: _____ Reachable Phone # _____Cell Phone # _____

Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage _____ Policy # _____

Parent(s) Name _____ Reachable Phone # _____ Cell # _____

Parent(s) Name _____ Reachable Phone # _____ Cell # _____

_____ _____

Parent /Guardian Signature **Date (valid for one year)**

Medication Consent Form - Consent Form 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)_____**

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

See reverse side of form for Medication Policies

Medication Policies

Prescription and Non-Prescription Medication:

- Requires specific written instructions signed by the physician and authorization by a parent or guardian for administration by the director or person designated to give medication at Maplewood Enrichment Center.
- 105 CMR 430 160(A) – Medication prescribed for children shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statement, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medication for children shall be kept in the original container, containing the original label, which shall include the directions for use.
- If a liquid medication is to be administered at the Maplewood Enrichment Center, the parent must provide the administration device with clear marked measurements (medicine sip-vial, medicine cup, dropper or syringe)
- 105 CMR 430 160(C) – Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. If the health care professional authorized to administer prescription medications, the administration of medication shall be under the professional oversight of the health care consultant. Medication prescribed for children brought form home shall only be administered from its original container; there is written permission form the parent/guardian and the health care consultant approved in writing the administration of the medication.
- Non-prescription ointment, topical lotion requires only a noted signed by a parent, specifying time and dosage (not to exceed 3 months). It must be in original container with legible label and child's name.
- 105 CMR 430 160(D) – When no longer needed, medications shall be returned to a parent or guardian whenever possible the medication cannot be returned, it shall be destroyed.

* Health supervisor - A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____
*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____
Any speech difficulties? _____
Special words to describe needs _____
Language spoken at home _____ *Any history of colic? _____
*Does your child use pacifier or suck thumb? _____ *When? _____
*Does your child have a fussy time? _____ *When? _____
*How do you handle this time? _____

HEALTH

Any known complications at birth? _____
Serious illnesses and/or hospitalizations:_____
Special physical conditions, disabilities:_____
Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____
_____
_____
Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____
*If infant is on a special formula, describe its preparation in detail: _____
Favorite foods: _____
Foods refused: _____
* Is your child fed held in lap?_____ High chair?_____
* Does your child eat with spoon?_____ Fork?_____ Hands?_____

TOILET HABITS

*Are disposable or cloth diapers used? _____*Is there a frequent occurrence of diaper rash?_____
*Do you use: oil:_____ powder:_____ lotion:_____ other:_____
*Are bowel movements regular?_____ How many per day?_____
*Is there a problem with diarrhea?_____ Constipation? _____
*Has toilet training been attempted?_____

*Please describe any particular procedure to be used for your child at the center: _____
_____

*What is used at home? Potty-chair? _____ Special child seat? _____ Regular seat? _____
*How does your child indicate bathroom needs (include special words): _____
Is your child ever reluctant to use the bathroom? _____
Does your child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____
Does your child become tired or nap during the day (include when and how long)? _____
_____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? _____ and get up in the morning? _____
Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____
_____

SOCIAL RELATIONSHIPS

How would you describe your child? _____
_____
Previous experience with other children/day care:_____
_____
Reaction to strangers:_____ Able to play alone?_____
Favorite toys and activities: _____
Fears (the dark, animals, etc.):_____
How do you comfort your child?_____
What is the method of behavior management/discipline at home? _____
_____
What would you like your child to gain from this childcare experience? _____
_____

DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____
_____
_____
Is there anything else we should know about your child? _____
_____
_____

_____ _____
(Parent/Guardian Signature) (Date)