

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical, dental, health, or hospital services, you as the parent must give permission. It's the law.

What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when you are away from home. To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

This is a legal document. With it, you may appoint relatives, friends, teachers, clergy, neighbors or anyone who is over 18 years of age – to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form carefully. Have your signature witnessed by an adult different from the person you are making responsible for your children. After you complete this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person – physician, dentist or hospital representative.

Names of Minors	Birthdates	Identify Allergies or Special Conditions

I/We, being the parents(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

The Jewish Community Center
Early Childhood Staff
 5655 Thompson Rd., Dewitt, NY 13214
 315-445-2040 ext. 120

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from the dates of:

June 28, 2010 through August 20, 2010

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent Signature	Date	Parent Signature	Date
Address		Address	
Witness Signature	Date	Witness Signature	Date
Address		Address	

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S):

Insurance Company or Government Program	ID or Contract Number
---	-----------------------

FAMILY PHYSICIANS

Name	Phone Number
Name	Phone Number

BABYSITTING AUTHORIZATION FORM

BABYSITTING AUTHORIZATION (This form is to be completed by the parent upon initial enrollment of each child.)

The undersigned parent, custodian or other adult responsible for (child's full name)_____ understands and acknowledges the Early Childhood Development Program and the Jewish Community Center (JCC) of Syracuse are not responsible for (child's full name)_____ 's care and welfare when the child is not in attendance. The Early Childhood Development Program and JCC are also not responsible for the actions of any JCC / Early Childhood Department Program staff member during any time other than such employee's scheduled work time at the Early Childhood Development Program.

I further understand and acknowledge that all information accessed by a JCC / Early Childhood Department staff member as a direct or indirect result of his / her employment is considered privileged and confidential and is not to be discussed with anyone outside the Center. Failure to abide by this professional code of ethics may result in immediate dismissal of the employee and/or withdrawal of my child(ren) for the remainder of the program.

I hereby waive and release the JCC / Early Childhood Development Program from any and all liability claims, actions, rights or damages of whatever type arising from babysitting performance by a JCC / Early Childhood Department staff member.

Child's Name	Age
Parent Signature	Date

- n This form is to be placed in the child's file.
- n Parent must place the ECDP employee's name in the child's file as an authorized person to pick up the child if the staff member will be taking the child from the center.
- n Final responsibility for the completion and return of this form rests with both parents and all ECDP employees to whom it applies.

Dear Parents:

As a licensed childcare facility, we are required to comply with legislation regarding the dispensing of medication. It is important that you are aware of the effects these regulations will have on you as a parent. Attached you will find the following 2 forms which need to be returned to school:

1. **Permission to Administer Over-the-Counter Topical Medications:**
This form must be completed by a parent in order for us to administer any over-the-counter topical medication. Please be aware that this form applies only to OTC Topical Medications, and is valid for 6 months.
2. **Medication Notification Agreement:**
Per regulations, we are required to document any instance when a child has been medicated or has received a treatment prior to coming to school.

Also attached you will find a ***Written Medication Consent Form***. This form must be completed by a parent and licensed authorized prescriber in order for us to administer any prescription medication or over-the-counter medication (with the exception of OTC topical medications).

This form must be updated every 6 months for all medication to be administered on an as-needed basis.

Finally, please be aware of the following regulations and procedures:

- All medication, along with the completed ***Written Medication Consent Form*** or ***Permission Form*** must be brought to the ECDP office by a parent.
- Medication will only be accepted in its original container. Over-the-counter medication must be labeled with the child's first and last name. prescription medication must contain the original pharmacy label with the child's name, medical provider's name, pharmacy name and telephone number, date prescription was filled, expiration date of the medication, dosage, how often to give the medication, and the date the medication should be discontinued or how many days the medication is to be given.
- Your child's medication (with the exception of OTC topical medications) will be administered in the ECDP office by a staff member who has received the training required by law to dispense medication.
- An individual health care plan will need to be developed for any child with special health care needs.

Please do not hesitate to contact us with any questions. Thank you in advance for your cooperation and compliance with these regulations.



MEDICATION NOTIFICATION AGREEMENT

MEDICATION NOTIFICATION AGREEMENT

I, _____, agree to notify my child care provider each time my child has been medicated or receives a treatment before coming to the Early Childhood Development Program. I will inform the Early Childhood Development Program of the name of the medication, the time it was given, and any side effects they should be aware of.

Child's Name

Parent Signature

Date

OVER-THE-COUNTER MEDICATION CHECKLIST

Please check off any over-the-counter topical medications that you may choose to bring for ECDP staff to administer for your child. If your child must use a specific brand of any of the products listed, please indicate the brand name of the product next to the category. If any brand is acceptable just check Yes or No beside the product.

Child's Name _____

Approval	Product	Does your child need to use a specific brand?	What is that brand? These items must be supplied by the parent.
Parent's Initial _____	Sunscreen	___ Yes ___ No	
Parent's Initial _____	Insect Repellent	___ Yes ___ No	
Parent's Initial _____	Diaper Cream	___ Yes ___ No	
Parent's Initial _____	Vaseline	___ Yes ___ No	
Parent's Initial _____	Antibacterial Hand Wipes	___ Yes ___ No	

Please check any of the following for which you give permission for ECDP to administer to your child in the event of a cut, scrape, or bite:

Approval	Product	Does your child need to use a specific brand?	What is that brand? These items must be supplied by the parent.
Parent's Initial _____	First Aid Cream/Spray	___ Yes ___ No	
Parent's Initial _____	Hydrogen Peroxide	___ Yes ___ No	
Parent's Initial _____	After Bite	___ Yes ___ No	
Parent's Initial _____	Calamine Lotion	___ Yes ___ No	
Parent's Initial _____	Bandage	___ Yes ___ No	

OVER-THE-COUNTER MEDICATION PERMISSION

I, _____ give permission to the Early Childhood Development Program to apply topical over-the-counter medications to my child, _____, according to label directions. I understand that the stocked brand may be used unless I have indicated a specific brand above.

This permission will be in effect from _____ to _____.

Parent Signature _____

Date _____

THIS FORM MUST BE UPDATED EVERY 6 MONTHS.

PERSONAL HISTORY

CHILD'S INFORMATION (One Form per Child)

Last Name	First Name	Birthdate	Age
Nickname		M / F	
Previous School or Camp Experience: _____			

MARITAL STATUS OF PARENTS

Mother/Guardian		Relationship of any other adults living in the home:	
Father/Guardian		Name	Relationship
Stepparent (s)			

ALLERGIES

Does child have any food or other allergies? Yes No (Please circle)

Please list allergies:

How do the allergies manifest themselves?

Treatment?

MEDICAL CONDITIONS

Please list any medical conditions:

SPECIAL EVALUATIONS

Has child had any special evaluations by speech/language therapist, psychologist or other special program? Yes No (Please circle)

If 'yes', please explain briefly and then fill out Special Needs Questionaire.

HEARING

Any difficulty with hearing, ear infections or tubes in ears? Yes No (Please circle)

If 'yes', please explain briefly.

TOILET TRAINING

Is child toilet-trained?	Yes No	What does he/she say when needs to urinate?
At what age?		What does he/she say for a bowel movement?
Are reminders needed?	Yes No	

PERSONAL HISTORY

CHILD'S INFORMATION (One Form per Child)

Last Name	First Name
-----------	------------

DRESSING

Does child need help to dress/undress self?	Yes	No
---	-----	----

SPEECH

Does child speak plainly so others beside those in family can understand?	Yes	No
---	-----	----

List any 'special words' child uses for family, friends or favorite things:	
---	--

HABITS

Does child suck thumb?	Yes	No	Does child usually appear happy?	Yes	No
Does child suck fingers?	Yes	No	Does child usually appear relaxed?	Yes	No
Does child bite nails?	Yes	No	Does child usually appear anxious?	Yes	No
Does child use a pacifier?	Yes	No	Does child usually appear fearful?	Yes	No
Is he/she right or left handed?	Right	Left	Does child appear to need more attention than average?	Yes	No

RELATIONSHIPS

Is child shy?	Yes	No	Is child relaxed with strange adults?	Yes	No
Is child outgoing?	Yes	No	Is child relaxed with other children?	Yes	No

FEARS

Does child display any symptoms of fear or anxiety?

Is there anything that has occurred in his/her life to help understand this?

EXPECTATIONS

What are your expectations or goals for your child while in our program?

SWIMMING

All children in Camps K'Ton Ton, Yeladim, & Gesher will be involved in age appropriate water readiness, safety, and structured swim lessons.
Does your child have a fear of water? _____
To what extend does your child swim? _____
Does your child have tubes or is unable to get his/her ears wet? _____

CAMP PERMISSIONS FORM

CHILD'S INFORMATION (ONE FORM PER CHILD)

Last Name	First Name	Age as of June 2010 ____ Years ____ Months
-----------	------------	--

PUBLICITY RELEASE FORM

Occasionally pictures of children engaged in their daily activities are utilized in ECDP publicity or promotions such as press releases, brochures or flyers. I give permission for my son/daughter _____ to be used in any school/camp publicity or promotion.

- .. I DO give permission for my child's photograph to be used.
- .. I DO NOT give my permission for my child's photograph to be used.

Parent Signature	Date
------------------	------

FIELD TRIP INFORMATION (Gesher Level Only)

I understand that I will be informed of the date, time and destination of each trip in advance. I further understand that field trips are an integral part of our program and the ECDP is unable to provide alternative care during the time of the trip if I am late and arrive after the scheduled departure time or choose not to have my child participate.

- .. My child has my permission to go on scheduled field trips.
- .. I do not want my child to participate in any field trip and am aware there is no alternate care.
- .. My child is enrolled on the toddler level and therefore this does not apply.

Parent Signature	Date
------------------	------

SECURITY

Dear Parents:

To control access to the Early Childhood wing, the entry doors are kept locked.

Entry is by an individually coded KEY FOB which will grant parents access weekdays between 7:30 am and 6:00 pm.

There is a \$10.00 refundable deposit for each key fob issued.

Although both entrances are equipped with a buzzer/speaker system connected to the ECDP office, please be aware that there are times that the ECDP receptionist must be away from her desk. Without a FOB you will not have access to the ECDP wing until she returns. Therefore, we advise that you obtain a key fob for each person that drops off or picks up your child on a regular basis.

The system is 'user friendly', while at the same time affording another layer of security for the children in our care and the staff working with them. Our hallway cameras supplement it.

Please fill out the form below and return it with the \$10.00 refundable deposit for each key fob ordered to the Early Childhood Office. Your coded key fob(s) will be available for you to pick up (at the ECDP Office weekdays between 7:30 am and 6:00 pm) within 5 business days.

Deposit is refundable up to 30 days after your last day of summer camp 2010.

ECDP KEY FOB DEPOSIT

Parent Name

Parent Name

Child's Name

PAYMENT INFORMATION

Total Amount \$ _____

Method of Payment: Cash Check (Sorry, we are unable to take credit cards for this expense)



SUMMER CAMP 2010 SPECIAL NEEDS QUESTIONNAIRE

This form should be filled out only if parents feel their child has some specific needs beyond those of normal development.
It need not be filled out for all children.

CHILD'S INFORMATION (One Form per Child)

Last Name	First Name	Age as of June 2010 ____ Years ____ Months
-----------	------------	--

Days and Times Attending:

If your child is not scheduled to attend our program full time or the days/times that coincide with the class in which we feel we can best meet his/her needs, will you be willing to consider making necessary adjustments in those times?

____ Yes ____ No

ISSUES (Please Check the Appropriate Box)

Please check if your child has exhibited a significant delay or need for remediation in any of the following areas of development. Note: if this was brought to your attention by a preschool, medical or other professional and any testing, assistance or treatment your child has or is currently receiving:

<input type="checkbox"/> Articulation	<input type="checkbox"/> Language
<input type="checkbox"/> Fine motor skills	<input type="checkbox"/> Gross motor skills
<input type="checkbox"/> Discipline (fighting, self control, etc.)	<input type="checkbox"/> Attention span
<input type="checkbox"/> Following instructions	<input type="checkbox"/> Other. Please explain: _____
<input type="checkbox"/> Sustained shyness/hesitancy in groups	_____
<input type="checkbox"/> Academic skills (letter, number recognition)	_____
<input type="checkbox"/> General maturity (ex: late birthday)	

KINDERGARTEN DELAY?

If your child was eligible to enter kindergarten September 2010 but is not, briefly highlight reasons for delaying entry:

Preschool Attended Last Year:

OTHER

Please share with us any other situations or characteristics of your child you feel would be helpful for us to know in order to meet his/her needs:



WRITTEN MEDICATION CONSENT

- The parent must ensure that all areas of the first page are filled out.
- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication the child is on. Multiple medications cannot be listed.
- Do not use this form to document administration of one-day only medication. Use the Verbal Medication Consent Form and Log of Administration.

INFORMATION

Child's First & Last Name		Date of Birth
Child's Known Allergies		
Provider/Facility Name Early Childhood Development Program	Facility ID Number 000400036DCC	Facility Phone Number 315-445-2040 Ext. 120

AUTHORIZED PRESCRIBER TO COMPLETE (except for over-the-counter topical ointments and sunscreen which parents must complete)

Licensed Authorized Prescriber's Name	Licensed Authorized Prescriber's Phone Number
Name of Medication (including strength if applicable)	Amount/dosage to be Given:
Date to be Discontinued or Length of Time in Days to be Given (up to 6 months)	Time(s) to be Administered (for non PRN medication)
Refrigeration Required <input type="radio"/> Yes <input type="radio"/> No	Route of Administration
Reason for Taking Medication (unless confidential by law)	
Possible Side Effects	
What Action to Take if Side Effects are Noted	
Special Instructions (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered)	

MEDICATION CONSENT/AUTHORIZATION

I, _____ authorize the **Early Childhood Development Program** to administer the medication listed above to
 Parent/Legal Guardian

 Child's Name

REQUIRED SIGNATURES

Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date
Name of Provider Who Received This Statement	Provider Signature	Date Received From Parent

SIGNATURE REQUIRED FOR ALL MEDICATION INSTRUCTIONS (except over-the-counter topical ointments and sunscreen lotion)

Licensed Authorized Prescriber's Name (print)	Licensed Authorized Prescriber's Signature	Date
---	--	------

MEDICATION DISCONTINUATION AUTHORIZATION (complete only if discontinue date is PRIOR to date listed above)

I, _____ request that the medication listed above be discontinued effective _____.
 Parent/Legal Guardian Medication Discontinue Date

Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date
---------------------------------	--------------------------------------	------