Waters
EARLY LEARNING CENTER

Known Allergies

Child's Name: _____ Date of Birth: _____

☐ My child has no Known Allergies. If I become aware of any Known Allergies I will alert the Program Director immediately.

☐ My child has the following Known Allergies. If I become aware of any other Known Allergies I will alert the Program Director immediately.

Known Allergy	Child's Reaction	Treatment

If the treatment for any of the above Known Allergies requires medication.
a Medication Consent Form will also need to be completed.

_____ _____
Parent / Guardian Signature Date

_____ _____
Administrator Signature Date

□ Entered on the Center Known Allergies List Employee Initials _____

□ Posted in the Child's Classroom and on Food Storage Cabinets Employee Initials _____

<u>This form is valid for one year from the date signed.</u>

Authorization for Medication

If your child requires an over the counter medication. such as Motrin or Tylenol. we are required by the state of Massachusetts to have proper authorization on file for each medication. These medications are generally left at the center to be used in the case of your child having a fever. teething. or other ailments directed by you and your child's physician. *Over the counter medication requires both parental and physician authorization.*

Provision of this form along with medication to the center is optional.

Name of Child: _____ First dose given at home: **Yes** **No**

Name of Medication: _____ Prescription: **Yes** **No**

My child has not 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: **Yes** **No**

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reason for medication: _____

Possible side effects: _____

Name of Physician: _____ Phone Number: _____

Directions for storage: _____

Special Instructions (i.e.. taken with food): _____

I (parent / guardian) give permission to authorized staff members of Waters Early Learning Center to administer medication to my child as indicated above.

_____ _____

Parent / Guardian Signature Date

Non-Prescription Medication

_____ _____

Physician Signature Date

□ Copied to the Emergency Evacuation File in the Medicine Cabinet Employee Initials _____

<u>This form is valid for one year from the date signed.</u>

Oral Health Non-Participation Form

In January 2010. EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts. which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However. parents may choose that their child not participate in tooth brushing while present at the child care program.

You do not need to fill out this form to have your child participate in tooth brushing while they are in child care. However. if you do not want your child to brush while attending school. please fill out the information below.

I do not wish to have my child participate in tooth brushing while in care at Waters Early Learning Center.

Child's Name: _____

Parent / Guardian Signature: _____

Date: _____

This form is valid for one year from the date signed.