SCHOOL-BASED RECREATION & LICENSED CHILDCARE PROGRAMS

INCIDENTAL MEDICAL SERVICES & PARENT AUTHORIZATION AGREEMENT

Date:_____

Child's Name: _____

Parent/Legal Guardian Name: _____

____My child will not require Incidental Medical Services during his/her time in the Licensed Child Care Program.

____My child may require Incidental Medical Services during his/her time in the Licensed Child Care Program. These services may include (initial by all that apply):

____Taking an oral medication
____Taking an inhaled medication
____Using an epi-pen
____Other (please describe _____)

Please choose and initial authorization of training from the options below:

____I understand that Child Care staff are trained in American Red Cross Pediatric First Aid or an EMSA approved class, and that this training describes how to handle administering oral medication, inhaled medication, and the use of an epi-pen. I authorize this training as acceptable in handling an Incidental Medical Service that may occur with my child.

____I prefer to train the staff myself in handling an Incidental Medical Service that may occur with my child. I trained the following staff to administer_____
_____ medications:

Staff Name:	Date Trained:
_____	_____
_____	_____
_____	_____

I authorize the trained staff at the _____ Child Care site to administer Incidental Medical Services to my child.

_____ _____
Parent's/Guardian's Signature *Date (MM/DD/YY)*