Helpful Hints/Paperwork Instructions

If you have questions, please don't hesitate to ask! We're happy to help 😊

(If child doesn't have medications or food allergies, you only need tp print pages 2-10)

KDHE required paperwork:

- CCL 010 – Authorization for Emergency Medical Care
  - I authorize, "SMCC Staff"
  - Between "(*insert first day of care*)" and "(end of care)"

- CCL 029 – Medical Record/Medical History
  - On this form, make sure you put a hospital preference (Wesley, Via Christi, etc) – it cannot say "closest" or "no preference". If you have multiples, please order them like this: 1st preference: _____, 2nd _____, etc.
- History of Immunizations
  - On this page, you can write "See attached" at the top if you have printed records from your doctor's office. Please make sure to still sign and date at the bottom.
- CCL 029a – Health Assessment
  - This form needs to be filled out by your child's doctor.
- (3 pages) CCL 034s
  - These forms are for permission to take the kids around school grounds and around town on walking trips. We do not take infants off school grounds, but the form is required for everyone.
- SMCC Non-Prescription Form
  - This form is for permission to use non-prescription items sent from home. Please insert the name brand of the items you plan to send from home. For example, if you will send Desitin diaper cream, you will check the diaper cream box and then insert "Desitin". For instructions, you may put "use as instructed on bottle" or provide your own instructions like "use with every diaper change".
- Social Media Release Form
  - We post pictures on our Facebook page for parents and community members to see! Join our page! https://www.facebook.com/stmargaretschildcare/
- CCL 026/CCL 027 – Medication Forms - (*only required if you plan to send medication from home*)
  - If your child is on any medications, please fill these out. Please note that any medications stored at the daycare will need to be in their original containers/boxes and labeled with your child's first and last name. We will keep them in locked storage in the office along with the required paperwork. Please bring meds directly to the office – do not leave in backpacks or cubbies where children could access them. Thanks!
- Meal Modification Form (MMF)/Allergy Treatment Plan (ATP) – *(only required for children with food allergies or sensitivities)*
  - The MMF will need to be signed by your child's doctor.
  - The ATP is a parent form to fill out for each classroom. We will add your child's photo, so don't worry about that part!

Curtis State Office Building
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1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

Kansas Department of Health and Environment

Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license	**License #**
St. Margaret's Child Care	80932

I authorize ____(*caregiver/staff*) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth________________________________ (*child's first and last name)* while child or youth is in the facility's custody between ________________ and ____________________.
MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

____

____

____

Signature of Parent or Guardian	**Date Signed**

- -

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premised from the facility.

CCL. 029
Rev. 07/2024

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Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment.
The Medical Record is transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender___
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact._____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____
Address _____
Phone Number _____

Name _____
Address _____
Phone Number _____

Child's Physician_____ Phone Number_____

Hospital Preference (for emergencies)_____

Any known allergies or medical conditions of child:_____

_____

Any major changes at home that might affect your child in care: _____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

Parent/Guardian Signature:_____ Date:_____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:** _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA _____HepB ____Hib
_____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:**_____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:_____ **Date:**_____

CCL. 029a
Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____IN/CM %ILE_____		**Weight: _____LB/KG %ILE_____**
Physical Examination	✓ **If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

CCL. 034
Rev. 3/2020

Kansas Department of Health and Environment
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Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			**License #**
St. Margaret's Child Care, LLC			
Street Address of the Facility	**City**	**Zip Code**	**County**
401 S Marion Street	Colwich	67030	Sedgwick

_____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Colwich Veterans Park (City Park)	530 W Chicago Ave (5th/Chicago)	Colwich	--------N/A---------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Colwich Memorial Park (near ICM)	500 E Chicago	Colwich	--------N/A---------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Colwich Community Library	432 W Colwich Ave	Colwich	-------N/A----------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Colwich Gardens (Asst. Living Home)	300 Chicago Ave	Colwich	---------N/A---------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Sacred Heart Catholic Church/REC	311 S 5th Street	Colwich	--------N/A---------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Duck Pond	On Homestead Drive	Colwich	---------N/A----------	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Gambino's Pizza	339 S 1st Street	Colwich	---------N/A----------	x
Signature of Parent or Guardian			**Date Signed**	

CCL. 034
Rev. 3/2020

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Name of the Facility (exactly as stated on the license)			License #
St. Margaret's Child Care			80932
Street Address of the Facility	**City**	**Zip Code**	**County**
401 S Marian	Colwich	67030	Sedgwick

_____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
CES Old Gym	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES New Gym	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES Library	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES Tornado Shelter/Music Room	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES Pre-K Room #032	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES Pre-K Room #034	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
CES Cafeteria	401 S Marian	Colwich	- N/A -	x
Signature of Parent or Guardian			**Date Signed**	

CCL. 034
Rev. 3/2020

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Name of the Facility (exactly as stated on the license)			License #
St. Margaret's Child Care LLC			80932
Street Address of the Facility	**City**	**Zip Code**	**County**
401 S Marian	Colwich	67030	Sedgwick

* _____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
CES Playground	401 S Marian	Colwich	- N/A -	X
Signature of Parent or Guardian			**Date Signed**	
*			*	

Place	Street Address	City	By Vehicle	Walk/Bike
Splash Park/Pad	500 E Chicago	Colwich	- N/A -	X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Post Office	417 W Wichita Ave	Colwich	- N/A -	X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Legacy Bank	123 E Chicago Ave	Colwich	- N/A -	X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
The Gathering Space	205 W Wichita Ave	Colwich	- N/A -	X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

SMCC NON-PRESCRIPTION AUTHORIZATION FORM:

I, _____ , authorize St. Margaret's Child Care Staff to administer the following items according to their original container or the written instructions below:

Child's Name: _____

- Sunscreen: _____
- Bug Spray: _____
- Lip Balm/Chapstick: _____
- Lotion: _____
- Diaper Cream: _____

Instructions:

_____

_____

_____

_____

_____

Parent Signature: _____ Date: _____

SOCIAL MEDIA CONSENT FORM

I, _____, hereby grant and authorize St. Margaret's the right to take, edit, copy, publish, distribute and make use of any and all pictures or video taken of my child(ren) to be used in and/or for legally promotional materials and digital communications including being shared on their Facebook page. This authorization shall continue indefinitely, unless I otherwise revoke authorization in writing. I understand and agree that these materials shall become the property of SMCC and will not be returned.

I hereby grant St. Margaret's permission to use my child's photos or videos however they'd like, unless specifically stated in writing below.

AGREE: Parental Signature: _____

OR

DISAGREE: (Written statement below)

_____
_____
_____
_____

Parental Signature: _____

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If child is not currently on short-term medication, you can skip this page

Authorization for Dispensing Medications to Children and Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication
(_____)_____
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature Date

Medication #2

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication
(_____)_____
Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form.
***Each designated person administering medication is to sign on the back side of this form and identify initials used.**

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

CCL.027
Rev. 5/2020

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If child is not currently on long-term medication, you may skip this page

Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

First and Last Name of Child/Youth _____ Date of Birth _____

Name of Medication (only one medication per authorization) _____ Prescription OR Non Prescription

Reason for Medication _____

Dose _____ Time to be Given _____ **Start Date** _____ **Stop Date**** _____

Name of Licensed Physician, PA or APRN prescribing the medication _____ Phone # of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

Parent's Signature _____ Date Signed _____

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form. *Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

*Signature of Designated Person Administering Medication ___________________________________ Initialing as___________

*Signature of Designated Person Administering Medication ___________________________________ Initialing as___________

*Signature of Designated Person Administering Medication ___________________________________ Initialing as___________

*Signature of Designated Person Administering Medication ___________________________________ Initialing as___________

Note Form

Date	**Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.**

Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a medical authority must be made to accommodate a participant's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

Part A. Participant, Parent/Guardian, Facility Contact Information – To be completed by a parent/guardian or facility contact person.

Participant's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
Facility Contact's Name:	Facility Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for facility personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate staff and to follow the prescribed diet order for meals. I also give permission for the medical authority to further clarify the prescribed diet order on this form if requested to do so by facility personnel.

Parent/Guardian's Signature: Date:

This institution is an equal opportunity provider.

ALLERGY TREATMENT PLAN

Attach child's photo

Child's Name: _____

Child's Birthday:_____

Parent Signature:_____

ALLERGIES

Please note severity: mild, moderate, or severe

KNOWN/PAST SYMPTOMS

OTHER/POSSIBLE SYMPTOMS

STEPS TO AVOID ALLERGY (SUBSTITUTIONS, ETC)

PLAN IN CASE OF ALLERGY EXPOSURE

◯ CALL 911 IMMEDIATELY
◯ MONITOR SYMPTOMS/NOTIFY PARENTS

MEDICATION TO BE ADMINISTERED:
NAME: _____ DOSE: _____ METHOD: _____
◯ IMMEDIATELY AFTER KNOWN OR SUSPECTED EXPOSURE
◯ ONLY IF CHILD DISPLAYS SYMPTOMS NOTED ABOVE
◯ OTHER/NOTES: