



BACK-UP CARE REGISTRATION FORM

CHILD'S INFORMATION:

Last Name _____ First Name _____

Date of Birth _____ Age _____ Gender: M/F

Allergies or other important information: _____

I give permission for my child's photo to be sent via the Tadpoles system. Initials _____

For security purposes, please provide both parent/guardian information

PARENT/GUARDIAN 1 INFORMATION:

Last Name _____ First Name _____ Gender: M/F

Home Address _____ City _____ State _____ Zip Code _____

Social Security Number ____-____-____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

PARENT/GUARDIAN 2 INFORMATION:

Last Name _____ First Name _____ Gender: M/F

Home Address _____ City _____ State _____ Zip Code _____

Social Security Number ____-____-____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

**CUSTODIAL ACKNOWLEDGEMENT:**

I understand that providing both parents/guardians information gives both parties the right to visit/pick up the above mentioned child at any time. If custody circumstances change for any reason, Lightbridge Academy must be notified in writing and we may request documentation by the proper authority.

Parent 1 Signature _____ Parent 2 Signature _____

CUSTODIAL INFORMATION:

If a non-custodial parent is not among those persons authorized to pick up the child, a court order must be provided. Please check the appropriate box below.

_____ Yes, this situation applies. A court order is attached.

_____ Not Applicable

EMERGENCY CARE AUTHORIZATION:

In the event that a medical emergency occurs, I authorize Lightbridge Academy to seek emergency care for my child as deemed necessary by the Director and I authorize such medical provider to carry out required emergency treatment.

Signature: _____ Date: _____

I understand and agree to the policies and requirements outlined in the Lightbridge Academy Handbook. In addition, I understand the Expulsion Policy and Information to Parents Statement made by the Office of Licensing (included in the Parent Handbook).

Parent/Guardian 1 Signature: _____ **Date:** _____

Parent/Guardian 2 Signature: _____ **Date:** _____

OFFICE USE ONLY:



EMERGENCY CONTACT INFORMATION FORM

(For Office & Classroom Emergency Binder)

Child's Name: _____

Child's Address: _____

Birth date: _____

Parent 1 Information:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Parent 2 Information:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Child's Allergy Information

Please list all allergies and any important information we need to know about your child including food he/she is NOT ALLOWED to have.

Emergency Contacts/ Authorized Pick – Ups

1. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone _____

2. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone: _____

3. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone: _____

In the event of a minor injury (cut, scrape, etc) would you like to be notified? _____

Which parent should we contact first in case of an emergency? _____



(Second page of Emergency Contact Form)

Child's Name _____

Dietary preferences _____

If cakes, cookies, or other treats are given as a snack in the event of a Birthday or other special occasion, do you object to your child consuming them? _____

Is a language other than English spoken at home? _____

If so, what language? _____

What Holidays do you and your family celebrate?

_____ New year's

_____ Valentine's day

_____ St Patrick's Day

_____ Easter

_____ Cinco de Mayo

_____ Independence Day

_____ Rosh Hashanah

_____ Ramadan

_____ Halloween

_____ Thanksgiving

_____ Chanukah

_____ Christmas

_____ Kwanzaa

_____ Diwali

Other(s): _____

Emergency Care Authorization:

In the event that a medical emergency occurs, I authorize Lightbridge Academy to seek emergency care for my child as deemed necessary by the director and I authorize such medical service provider to carry out required emergency treatment.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____



Child's Name: _____

Parent's Signature: _____

Please bring in copies of identification (i.e. drivers license) on or before your child's first day at Lightbridge Academy®.

Please attach:

Parent / Guardian 1's License:

Parent / Guardian 2's License:



MEDICATION ADMINISTRATION PACKET

Dear Parents,

This packet contains a Medication Administration Policy as well as other policies to help us provide the best possible care for your child. They include: Diaper Cream Permission, Sunscreen & Insect Repellent Permission, Medication Authorization Form,

These policies are in accordance with the most up to date state and federal regulations. Please take the time to read through below on the new uses and guidelines of these forms.

1. Medication Administration Policy-Please read through, sign and return to the center.
2. Medication Authorization Form. Our suggestion is to keep this in the glove box of your car so that any time you are taking your child to the doctor you will have it on hand. **No medication will be administered without these forms completed by both a parent and health care provider.**
3. Permission for Sunscreen and Insect Repellent. This form must be completed in order to administer sunscreen or insect repellent.
4. Authorization for Diaper Cream and Topical Lotions. This form is for over the counter diaper cream or lotions and must be completed in order to administer either product.
5. Care Plan for Children with Special Health Needs-This form needs to be completed by the health care provider in the event a child has any special health needs including asthma or allergies. This form should be updated in the event of a change of how the health need will be treated or every August, whichever comes first. Please see your Director if your child requires this form.
6. Food Allergy and Anaphylaxis Emergency Care Plan & Asthma Action Plans-These should be completed by both the health care provider and the parent/guardian. These should be updated when there is a change in treatment or every August. Please see your Director if your child requires this form.

What to do now:

- Carefully read through the Medication Administration Policy.
- Discuss any questions with the center Director.
- Sign and return the Medication Administration Policy.
- If your child suffers from any food allergies or asthma, have your health care provider complete the appropriate action plans and promptly return them to the center.
- If your child is currently in need of prescription diaper rash lotions or other topical lotions, have your health care provider complete the authorization record and promptly return to the center.
- If your child is currently in need of over the counter diaper rash lotions or other topical lotions, have your health care provider complete the authorization record and promptly return to the center.

What to prepare for:

- Keep copies of Medication Authorization Form in your car. It will be on hand for when you visit your child's health care provider. This form must be completed by a health care provider before any medication is administered at the Center.
- We are required to maintain yearly updates to these records. These forms will be updated every August.

All forms must be returned to the office upon registration. As always, please feel free to stop in the office if you have any questions.



MEDICATION ADMINISTRATION POLICY

PURPOSE: This policy was written to encourage communication between the parent, the child's health care provider and the child care provider to assure maximum safety in the giving of medication to the child who requires medication to be provided during the time in child care.

INTENT: Assuring the health and safety of all children in our Center is a team effort by the child care provider, family, and health care provider. This is particularly true when medication is necessary to the child's participation in child care.

GUIDING PRINCIPLES AND PROCEDURES:

1. Whenever possible, it is best that medication be given at home. Dosing of medication can frequently be done so that the child receives medication prior to going to child care, and again when returning home and/or at bedtime. The parent/guardian is encouraged to discuss this possibility with the child's health care provider.
2. The first dose of any medication should always be given at home and with sufficient time before the child returns to child care to observe the child's response to the medication given. When a child is ill due to a communicable disease that requires medicine as a treatment, the child must have been on the prescribed medication for 24 hours before returning to child care. This is for the protection of the child who is ill as well as the other children in child care.
3. Medication will only be given when ordered by a child's health care provider and with written consent of the child's parent/legal guardian. A Medication Authorization Form is attached to this policy. All information on the Medication Authorization must be completed before the medication can be given. Copies of this form can be duplicated or requested from the child care provider.
4. "As needed" medications may only be given when the child's health care provider completes a Medication Authorization form that lists specific reasons and times when such medication can be given.
5. Medications given in the Center will be administered by a staff member designated by the Center Director and will have been informed of the child's health needs related to the medication and will have had training in the safe administration of medication.
6. Any prescription or over-the-counter medication brought to the child care center must be specific to the child who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the appropriate information as follows:
 - a. Prescription medication must have the original pharmacist label that includes the pharmacist's phone number, the child's full name, name of the health care provider prescribing the medication, name and expiration date of the medication, the date it was prescribed or updated, and dosage, route, frequency, and any specific instructions for its administration and/or storage. **It is suggested that the parent/guardian ask the pharmacist to provide the medication in two containers, one for home and one for use in child care.**
 - b. Over the COUNTER (OTC) medication must have the child's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible. **The prescription for all over the counter medications must expire within 30 days.**
 - c. ANY OTC medication must have a completed Medication Authorization from the health care provider.
 - i. Examples of over-the-counter medications that may be given include:
 1. Topical or oral antihistamines
 2. Decongestants
 3. Non-aspirin fever reducers/pain relievers
 4. Cough Suppressants
 5. Teething medication such as Orajel
 6. Topical itch or rash relief cream such as hydrocortisone
 7. Gas relief drops or gripe water
 - ii. Exceptions of OTC items that do not require a Medication Authorization Form include non-prescription diaper cream, sunscreen and insect repellent. These items require a Lightbridge Academy designated form completed by the child's parents.
 - d. All medications will be stored:
 - i. Inaccessible to children



- ii. Separate from staff medications
- iii. Under proper temperature control
- iv. A box will be used in the kitchen to hold medications requiring refrigeration
- v. All medications not requiring refrigeration will be stored in the office
- vi. Life-saving medication will be stored in the child's classroom
- e. Single dose medication or sample doses from the physician's office will not be administered.
- f. For safety reasons, medications or procedures that are considered invasive will not be administered or carried out.
 - i. Examples of invasive medications and procedures include:
 - 1. Eye drops
 - 2. Ear drops
 - 3. Nose drops
 - 4. Taking temperature orally or rectally
- g. For safety reasons, procedures that are considered unsafe will not be carried out.
 - i. Examples of unsafe procedures include:
 - 1. Splinter removal
 - 2. Bee sting removal
 - 3. Tick removal
 - 4. Nail cutting
- 7. For the child who receives a particular medication on a long-term daily basis, the staff will advise the parent/guardian one week prior to the medication needing to be refilled so that needed doses of medication will not be missed.
- 8. Unused or expired medication will be returned to the parent/guardian when it is no longer needed or able to be used by the child.
- 9. Records of all medication given to a child are completed in ink and are signed by the staff designated to give the medication. These records are maintained in the Center.
- 10. Information exchange between the parent/guardian and child care provider about medication that a child is receiving should be shared when the child is brought to and picked-up from the Center. Parents/guardians should share with staff any problems, observations, or suggestions that they may have in giving medication to their child at home, and likewise with staff from the center to the parent/ guardian.
- 11. Confidentiality related to medications and their administration will be safeguarded by the Center Director and staff. Parents/Guardians may request to see/review their child's medication records maintained at the Center at any time.
- 12. Parent/guardian will sign all necessary medication related forms that require their signature, and particularly in the case of the emergency contact form, will update the information as necessary to safeguard the health and safety of their child.
- 13. Parent/guardian will authorize the director to contact the pharmacist or health care provider for more information about the medication the child is receiving, and will also authorize the health care provider to speak with the Center Director in the event that a situation arises that requires immediate attention to the child's health and safety particularly if the parent/guardian cannot be reached.
- 14. Parent/guardian will read and have the opportunity to discuss the content of this policy with the Director. The parent signature on this policy is an indication that the parent accepts the guidelines and procedures listed in this policy, and will follow them to safeguard the health and safety of their child. Parent/guardian will receive a copy of the signed policy including single copies of the records referenced in this policy upon request.

Parent/legal guardian signature (s):

_____ Date_____

_____ Date_____

References: Information for the Medication Administration in Child Care policy was derived from the current **Manual of requirements for Child Care Centers** in New Jersey and **Caring for Our Children**-The National Health and Safety Performance Standards for Out-of-Home Child Care Programs, second edition.



MEDICATION AUTHORIZATION FORM FOR MEDICATIONS, DIAPER CREAM AND TOPICAL LOTIONS

(Please use one form per medication)

The following information is to be completed by the child's health care provider:

Child's Name: _____
Birth date: _____ Wt: _____
Medication: _____ Allergies: _____
Dosage: _____ Route: _____
Time of day medication is to be given: _____
Purpose of medication: _____
Special Instructions: _____
Possible Side Effects: _____
Start Date: _____ End date: _____

Signature of Health Care Provider

Phone Number

Date

The following is to be completed by the Parent or Guardian:

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine. **I authorize the Director to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director to contact the health care provider regarding my child's health if necessary.**

I usually do the following to make giving medication to my child easier:

Amount of medication brought to Child Care: _____

Date

Signature of Parent or Guardian

Date and amount of medication returned to parent _____

Signature of Director

Signature of Parent/Guardian



AUTHORIZATION FOR DIAPER CREAM AND TOPICAL LOTIONS

This section is to be completed by Parent/Guardian:

Name of Child: _____ Birth date: _____
Health Care Provider Name: _____ Phone Number: _____
Health Care Providers Address: _____
Name of Medication: _____ Purpose: _____
Times to be applied: _____
Amount to be applied: _____
Where should be lotion be applied: _____
Special instructions: _____
Possible Side Effects: _____
Start Date: _____ End Date: _____

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. **I authorize the Director to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director to contact the health care provider regarding my child's health if necessary**

*For over the counter creams and lotions, this form must be completed annually or with a change in brand.

Signature of Parent/Guardian

Date



AUTHORIZATION FOR SUNSCREEN & INSECT REPELLENT

Child's Name: _____ Birth date: _____
Name of Health Care Provider: _____ Phone Number: _____
Allergies: _____

I hereby grant permission to Lightbridge Academy Child Care, or any staff that they designate able, to apply sunscreen on my child _____. I understand that the sunscreen will be applied on the days that my child is participating in outdoor play. I also am aware that it is my responsibility to provide the sunscreen to Lightbridge Academy.

Please Note: For the safety of the children in our care, aerosol sunscreen is not permitted to be used.

Name of Sunscreen: _____

Application Directions: _____

I hereby grant permission to Lightbridge Academy Child Care, or any staff that they designate able, to apply insect repellant on my child _____. I understand that the insect repellant will be applied by request of parent/guardian on days that my child is participating in outdoor play. Insect repellant will be applied to summer camp children on all trip days. I also am aware that it is my responsibility to provide the insect repellant to Lightbridge Academy.

Name of insect repellant: _____

Application Directions: _____

Parent Signature: _____

Date: _____