



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## YMCA OF SAN DIEGO COUNTY 2016 - 2017 LICENSED PROGRAM REGISTRATION CHECKLIST

CHILD'S NAME	SCHOOL/PRESCHOOL
--------------	------------------

### ALL REGISTRANTS

- Registration Fee or Family Membership
- Licensed Program Registration (2 pages)
- Licensed Program ATS Application
- LIC 700 Identification and Emergency Information
- LIC 702 Child's Preadmission Health History
- LIC 613A Personal Rights
- LIC 627 Consent for Emergency Medical Treatment
- LIC 995 Notification of Parents' Rights
- LIC 9221 Parent Consent for Administration of Medications (If Applicable)\*

\*If your child requires incidental medical services (such as epi-pen or inhaler) additional forms must be completed prior to enrollment.

### ADDITIONAL FOR INFANT/TODDLER/PRESCHOOL REGISTRANTS ONLY:

- LIC 701 Physician's Report
- Lead Blood Test
- Immunization Records

**IN ORDER FOR YOUR CHILD TO ATTEND, ALL FORMS LISTED ABOVE NEED TO BE COMPLETED AND TURNED IN.**

#### FOR OFFICE USE ONLY

I have received all documents listed above.

Staff's Name: \_\_\_\_\_ Date Received: \_\_\_\_\_



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## YMCA OF SAN DIEGO COUNTY 2016-2017 LICENSED PROGRAM REGISTRATION

CHILD'S NAME	GENDER (M/F)	BIRTH DATE	GRADE
SCHOOL/PRESCHOOL		CLASS ROOM #	PROGRAM START DATE
PARENT/GUARDIAN NAME		PHONE NUMBER	EMAIL ADDRESS
PARENT/GUARDIAN NAME		PHONE NUMBER	EMAIL ADDRESS

<p><b>ALLERGIES/DIETARY RESTRICTIONS</b> The safety of your child and other children in the classroom is our top priority. Please check all that apply.</p> <p><input type="checkbox"/> INSECT STING    <input type="checkbox"/> HAY FEVER    <input type="checkbox"/> INSECT STING</p> <p><input type="checkbox"/> PENICILLIN    <input type="checkbox"/> GLUTEN    <input type="checkbox"/> OTHER: _____</p> <p><input type="checkbox"/> NUTS: _____</p>	<p><b>CONDITIONS REQUIRING CONSIDERATION</b> The safety of your child and other children in the classroom is our top priority. Please check all that apply.</p> <p><input type="checkbox"/> ADD/ADHD    <input type="checkbox"/> ASTHMA    <input type="checkbox"/> BLEEDING DISORDERS</p> <p><input type="checkbox"/> DIABETES    <input type="checkbox"/> SEIZURES    <input type="checkbox"/> OTHER: _____</p>
--	---

**SELECT ONE OF THE FOLLOWING MONTHLY PLANS:**

<input type="checkbox"/> AM/PM Five Day <input type="checkbox"/> Participant \$ 515.00 <input type="checkbox"/> Family Member \$ 438.00 <b>Days your child will attend:</b> <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> Tu <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> Th <input checked="" type="checkbox"/> F	<input type="checkbox"/> AM/PM Three Day <input type="checkbox"/> Participant \$ 355.00 <input type="checkbox"/> Family Member \$ 304.00 <b>Days your child will attend:</b> <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F
<input type="checkbox"/> AM Five Day <input type="checkbox"/> Participant \$ 160.00 <input type="checkbox"/> Family Member \$ 135.00 <b>Days your child will attend:</b> <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> Tu <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> Th <input checked="" type="checkbox"/> F	<input type="checkbox"/> AM Three Day <input type="checkbox"/> Participant \$ 108.00 <input type="checkbox"/> Family Member \$ 93.00 <b>Days your child will attend:</b> <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F
<input type="checkbox"/> PM Five Day <input type="checkbox"/> Participant \$ 366.00 <input type="checkbox"/> Family Member \$ 309.00 <b>Days your child will attend:</b> <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> Tu <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> Th <input checked="" type="checkbox"/> F	<input type="checkbox"/> PM Three Day <input type="checkbox"/> Participant \$ 247.00 <input type="checkbox"/> Family Member \$ 209.00 <b>Days your child will attend:</b> <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F

**INITIAL ATTENDANCE AND FEE SCHEDULE**

In order to register your child for one of our programs, you will need to have all forms completed and be prepared to pay the registration fee and first month's tuition. The registration fee is \$50 and is waived with a family membership.

**ACKNOWLEDGMENTS - Please read and initial each item below**

Parent/Guardian Initials	I have received the Family Handbook and I am responsible for reading and abiding by the Policies and Procedures as set forth by the YMCA.
Parent/Guardian Initials	Monthly payments are made via Automatic Transfer System (ATS) on the 10th (for checking accounts) or the 15th (for credit cards). Notification of changes or corrections must be made to information on file by the 1st of each month in writing via an ATS Form. A \$ 20 service fee will be applied for accounts returned unpaid, closed or payments stopped. I understand that it is my responsibility to notify the YMCA.
Parent/Guardian Initials	Cancellations are required in writing, two weeks prior to your child's last day in the program. Failure to do so will result in financial responsibility for payment. No refunds are given. I understand that I am required to give two weeks written notification to withdraw from the program.
Parent/Guardian Initials	I understand that I am responsible for ensuring my child is signed in and out of the facility by an authorized adult (18+ years old) on a daily basis.
Parent/Guardian Initials	I understand that, after completing registration, it will take 48 hours before my child can begin attending the program.

**I understand all the policies and procedures in the YMCA of San Diego County 2016-2017 Licensed Program Registration.**

**Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**

**YMCA RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT FOR MINORS**

**Name of Minor(s) \_\_\_\_\_**

I, the undersigned parent/person having legal custody/guardianship of the above said minor, give permission for the minor to participate in all YMCA programs. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program.

In consideration of said minor being permitted to enter any branch of the YMCA of San Diego County ("YMCA") for observation, use of facilities and/or equipment, or participation of the above in any program, I, on behalf of myself (as parent, guardian, coach, aide, spectator or participant) hereby:

1. Acknowledge that (i) I have read this document, (ii) I have inspected the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document.

Except for YMCA's gross negligence or willful misconduct I release the YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me or the above said minor, for any loss or damage to property or injury or death to person, whether said damage or injury results from conditions arising upon the YMCA facilities or arising out of or in connection with YMCA programs or activities. YMCA shall not be liable for any damages arising from any act or neglect of any other member, occupant or user of the YMCA premises or participant in YMCA programs or activities. I agree that the above said minor assumes full responsibility for, and risk of, bodily injury, death or property damage except caused or due to the gross negligence or willful misconduct of the YMCA.

2. I agree not to sue Releasees for any loss, damage, injury or death described above and except for YMCA's gross negligence or willful misconduct, I will indemnify, protect, defend and hold harmless the YMCA and its Releasees from and against any and all claims and/or damages, liens, judgments, penalties, attorneys' and consultants' fees, expenses and/or liabilities arising out of, involving, or in connection with, the YMCA membership, use of YMCA facilities and/or participation in YMCA programs by me, the above said minor or any other person. If any action or proceeding is brought against YMCA by reason of any of the foregoing matters, I shall upon notice defend the same at my expense by counsel reasonably satisfactory to YMCA and YMCA shall cooperate with me in such defense. YMCA need not have first paid any such claim in order to be defended or indemnified.

3. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care.

I intend this document to be as broad and inclusive as is permitted by the laws of the State of California; if any portion hereof is held invalid, I agree the balance shall continue in full force and effect.

**Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Waiver/Consent**

I, \_\_\_\_\_ give my permission to the YMCA of San Diego County (YMCA) to use my picture or other likeness, or a picture or other likeness of any of my children, specifically, \_\_\_\_\_, in the YMCA's general publicity and campaign materials.

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

**The YMCA of San Diego County is dedicated to improving the quality of human life and to helping all people realize their fullest potential as children of God through the development of the spirit, mind and body.**



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## YMCA OF SAN DIEGO COUNTY LICENSED PROGRAM ATS APPLICATION

CHILD'S NAME		BIRTH DATE	
SCHOOL/PRESCHOOL			
PARENT NAME(S)			
CHECK OR CARD ACCOUNT HOLDER'S NAME(S)			
CREDIT CARD NUMBER		EXPIRATION DATE	
BILLING ADDRESS (STREET NUMBER, STREET NAME, CITY, STATE, ZIP CODE)			
HOME PHONE   CELL PHONE		WORK PHONE	
EMAIL ADDRESS			

PAYMENT INFORMATION

Automatic payments occur monthly.  
Checking accounts on the 10th and credit/  
debit cards accounts on the 15th.

Please Initial: \_\_\_\_\_

Changes to automatic payments must  
be submitted in writing and at least 2  
weeks/days prior to draft date.

Please Initial: \_\_\_\_\_

Check or Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the YMCA of San Diego County to initiate debits to the bank/credit account attached. This authority is to remain in full force and effect until the YMCA or BANK has received the 14 days written notification from me (us) of its termination in such a manner as to afford the YMCA or BANK a reasonable opportunity to act on it. A \$ 20.00 service fee will be applied for accounts returned unpaid, closed, or payment stopped. I understand there are no refunds given. I understand it is my responsibility to check my monthly bank statement and report any corrections immediately to the YMCA.

**FOR CHECKING ACCOUNT PLEASE ATTACH A VOIDED CHECK**

DATE RECEIVED	DRAFT BEGIN DATE	FIRST MO. DRAFT FEE	DRAFT DATE	ENTERED CCC	ENTERED EXCEL	COMMENTS

**NOTES AND ADJUSTMENTS**

ATTACH VOIDED CHECK HERE

**IDENTIFICATION AND EMERGENCY INFORMATION  
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**

**To Be Completed by Parent or Authorized Representative**

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ( )					
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ( )					
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

**ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY**

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

**PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY**

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL       OTHER      EXPLAIN: \_\_\_\_\_

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	DATE LEFT
-------------------	-----------

**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

**DEVELOPMENTAL HISTORY** (\*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
--	------------------------	---

**DAILY ROUTINES** (\*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES? ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
--------------------	------

# PERSONAL RIGHTS

## Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
  - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
  - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
  - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
  - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
  - (6) Not to be locked in any room, building, or facility premises by day or night.
  - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

7575 Metropolitan Way Suit 110

CITY

San Diego

ZIP CODE

92108

AREA CODE/TELEPHONE NUMBER

DETACH HERE

**TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:**

**PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD  
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

\_\_\_\_\_ HOME PHONE  
( )

\_\_\_\_\_ WORK PHONE  
( )



## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

---

### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Community Care Licensing

Licensing Office Address: 7575 Metropolitan Way Suit 110, San Diego, CA 92108

Licensing Office Telephone #: 619-767-2200

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

**NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.**

*For the Department of Justice "Registered Sex Offender" database, go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

---

### ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

\_\_\_\_\_  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.**

*For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

---

## PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

**NOTE:** Regulation Section 101221 requires the following information be on file.

CHILD CARE CENTER NAME:	LICENSE NUMBER:	DATE:

**PARENT'S INSTRUCTIONS:**

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME	DOSAGE

**I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:**

---

From \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_ daily while in attendance.  
BEGINNING DATE                      ENDING DATE                      TIME OF DAY

PARENT'S SIGNATURE:	DATE:

**MEDICATION CHART**  
**Staff Documentation of Medicine Administration**

DATE	TIME GIVEN	STAFF SIGNATURE

**Upon completion, return medicine to parent or destroy, and place form in child's record.**

STAFF	DATE