DPHHS CCL 113 Revision
Date: June 2023

Emergency Contact and Consent

This form must accompany staff when children are away from the childcare site

Child's Name (First, Last)	
Date of Birth	

ALLERGY ALERT **Does your child have allergies? ☐ YES ☐ NO If yes, list all allergies in required box.**

Parent or Guardian Contact Information

Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone

Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child

Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship

Required Medical Information

Primary Medical Care Provider	Phone
Health Concerns (Please explain)	
Allergies	

Parent or Guardian Authorization

In an emergency, the child care facility has my permission to provide or obtain emergency medical treatment including transporting child by ambulance or vehicle if necessary. The parent/guardian of the child will be notified as soon as possible.

Parent/Guardian Signature **Date**

(This form must be completed and signed annually)

STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.

SECTION I *PLEASE PRINT CLEARLY*

Child/Student's Name	Birth Date	Sex	Primary Provider	
Name of Parent/Guardian	Address		City	Telephone Home Work

SECTION II IMMUNIZATION HISTORY

Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).

Required Vaccines (CC= Child Care Requirement; SR=School Requirement)	Month, Day & Year of Each Dose 1	2	3	4	5
Diphtheria/Tetanus/Pertussis (DTaP)					
Booster Dose Tdap required prior to 7th grade entry					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					
Measles/Mumps/Rubella (MMR)					
or					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has documentation of disease					
Hepatitis B					
Pneumococcal Conjugate vaccine (PCV13)					

ACIP* Recommended Vaccines *Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention	Month, Day & Year of Each Dose 1	2	3	4	5
Hepatitis A					
Human Papillomavirus (HPV) - for adolescents					
Influenza- recommended annually for all over 6 mos.					
Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later)					
Rotavirus					

NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION

If filled out by health department or health care provider:

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

If filled out by school or child care personnel:

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth ____/____/____

Program Name _____

****

I give permission for the administration of the following non-ingestible over the counter medications (mark all that apply):

- ☐ Diaper Rash Cream/Ointments _____
- ☐ Insect Repellent _____
- ☐ Sunscreen _____
- ☐ Cortisone/Anti-Itch Creams/Ointments _____
- ☐ Medicated Lip Treatments _____
- ☐ OTC Antibiotic Creams/Ointments _____
- ☐ Burn Creams/Sprays _____
- ☐ Other Non-Ingestible OTC's: (Please Specify) _____

_____

_____

To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent;
- The medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____ Refrigeration**?** ____

Parent/Guardian Signature (required)_____ Date: ____ / ____ / _____

*** This document must be updated on an annual basis.**

Unused Medication: (check one) Returned to Parent Y☐ N☐ Discarded appropriately Y☐ N☐

By: _____ **Date:** ____ / ____ / _____

***Keep in the child's file when medication is finished.**

ITEMS TO PROVIDE FOR YOUR CHILD

TO REMAIN AT SCHOOL:

- ☐ SUPPLIES FOR NAP
  -A CRIB SHEET & BLANKET
  OR A SLEEPING BAG

- ☐ WATER BOTTLE
  -PREFERABLY LEAK PROOF
  LABELED WITH NAME

- ☐ EXTRA CLOTHES
  -SHIRT, PANTS/SHORTS,
  UNDERWEAR & SOCKS

- ☐ WEATHER APPROPRIATE
  OUTSIDE CLOTHING
  -EX: SNOW PANTS, COAT, HAT,
  MITTENS & SNOW BOOTS

GROWING ROOTS PHOTO RELEASE FORM

Child's Full Name: _____
Parent/Guardian Name: _____
Date: _____

Please read the following statements carefully and check the appropriate boxes.

1. I grant permission for Growing Roots Early Learning Center to use photographs of my child, _____, for promotional purposes, including but not limited to brochures, newsletters, the preschool's website, and social media.
   - ☐ Yes
   - ☐ No
2. I agree that these photographs may be used in publications, advertisements, and online media, and I understand that no compensation will be provided for these uses.
   - ☐ Yes
   - ☐ No
3. I understand that my child's full name will not be used in conjunction with the photographs without my additional consent.
   - ☐ Yes
   - ☐ No
4. I acknowledge that I have the right to withdraw this consent at any time by providing written notice to Growing Roots Early Learning Center.
   - ☐ Yes
   - ☐ No

Signature of Parent/Guardian: _____
Date: _____