

# Emergency Contact and Consent



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

<b>Child's Name (First, Last)</b>		
<b>Date of Birth</b>		
<b>ALLERGY ALERT</b> Does your child have allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list all allergies in required box.		
<b>Parent or Guardian Contact Information</b>		
<b>Name (First, Last)</b>		<b>Relationship</b>
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
<b>Name (First, Last)</b>		<b>Relationship</b>
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
<b>Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child</b>		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
<b>Required Medical Information</b>		
<b>Primary Medical Care Provider</b>		<b>Phone</b>
<b>Health Concerns</b> (Please explain)		
<b>Allergies</b>		
<b>Parent or Guardian Authorization</b>		
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.		
<b>Parent/Guardian Signature</b>		<b>Date</b>
<i>(This form must be completed and signed annually)</i>		

# 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 7 <sup>th</sup> 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] <input type="checkbox"/> Check here if child has documentation of disease					
Hepatitis B					
Pneumococcal Conjugate vaccine (PCV13)					

ACIP* Recommended Vaccines <small>*Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention</small>	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:**

**If filled out by school or child care personnel:**

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

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

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*

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 \_\_\_\_\_

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**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-Ingester 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

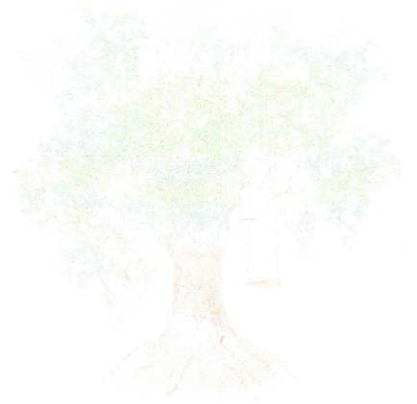
\* **This document must be updated on an annual basis.**

**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

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- WATER BOTTLE  
-PREFERABLY LEAK PROOF  
LABELED WITH NAME

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

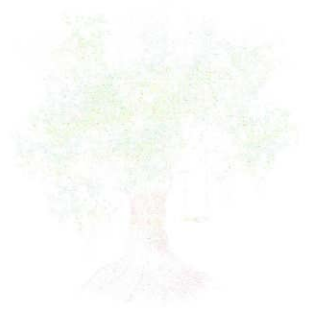
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- WEATHER APPROPRIATE  
OUTSIDE CLOTHING  
-EX: SNOW PANTS, COAT, HAT,  
MITTENS & SNOW BOOTS

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# GROWING ROOTS

## PHOTO RELEASE FORM



Student Name: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_, acknowledge that during fun events such as learning activities, field trips, projects and daily events; photos of my child can be taken. I acknowledge that these photos can be used for promotional or documenting purposes by Growing Roots Early Learning Center.

By signing below, I grant permission to Growing Roots ELC to take and use photographs/videos of my child. I understand that this can be through forms such as social media, posters, flyers, ads, on their website, etc.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_