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
Hepatiis 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*

DPHHS-QAD/CCL-120
(Revision 11/19)

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.**

Department of Public Health and Human Services
Child Care Licensing Bureau
Pediatric Health Statement

Infant/Child's Name: _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

EXAMINATION:

Known Health Conditions: _____

Allergies (specific): _____

Special Medication: _____

Immunizations Current: _____

Restrictions: _____

Comments: _____

_____

_____

I have examined _____ **and find no unusual health risks to him/her or to other children in the day care setting.**

_____
(PLEASE PRINT - Medical Professional's Name)

_____ **Date:** _____
(Signature of Medical Professional)

PLEASE CONSULT: **ARM 37.95.128**

Infant Feeding Plan

*A written plan shall be maintained on file and available for the caregiver of any child less than 12 months of age and must be updated as **feedings change.***

Child's Name:	***Date:***	***Birthdate:***

Formula:

☐No ☐Yes Is your child fed formula[1]?

☐No ☐Yes Will formula be prepared (mixed) at home?

☐No ☐Yes Will formula be prepared by the caregiver?

If the caregiver will be preparing the formula, please indicate any special instructions:

_____

Breast Feeding/Breastmilk

☐No ☐Yes Is your child breast fed?

☐No ☐Yes I will nurse my child at the center at these times:

_____

☐No ☐Yes I will provide breast milk[1].

If breast milk is unavailable for a feeding, the center should:

_____

Feedings:

☐No ☐Yes Does your child take a bottle? (Note: Bottles are required to be labeled with child's name and the current date.)

- ☐No ☐Yes Is the bottle warmed[2]?
- ☐No ☐Yes Does your child hold their bottle?
- ☐No ☐Yes Can the child feed his or herself?
- ☐No ☐Yes Are there any special instructions for bottle feeding your child?

If "yes," please explain:

_____

☐No ☐Yes Is your child using a sippy cup? (Note: Sippy cups must be labeled with the child's name.)

☐No ☐Yes Does your child have any problems with feeding, such as choking or spitting up?

If "yes," please explain:

_____

☐No ☐Yes Are there any special instructions concerning feeding your child?

If "yes," please explain:

_____

Foods and Feeding Schedule:

Liquids (formula, breastmilk)	☐N/A ☐Introducing ☐Familiar	☐Breast Feeding ☐by bottle ☐by breast ☐Bottle Feeding ☐by caregiver ☐with help ☐independently ☐Cup Feeding ☐with help ☐independently		Amounts:
Semisolid Foods (infant cereal, strained fruits and/or vegetables)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independentiy	Kinds of Food:	Amounts:
Modified Table Foods (mashed, soft, diced fruit and /or vegetables, strained meat or poultry, pieces of soft bread)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Finger Foods (small pieces of soft/cooked table food, chopped food)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:

Other:

☐No ☐Yes Does your child take a pacifier?

Note: Pacifiers with straps or other types of attachment devices are not permitted. Pacifiers must be removed when the child is crawling or walking.

Additional Information:

I will promptly provide any updates to my child's feeding plan as needed.	***PARENT'S SIGNATURE:***	***DATE:***

[1]Breast milk shall be gently mixed but not be shaken. Refrigerated breast milk shall be used within 24 hours. Formula or breast milk that is served, but not completely consumed or refrigerated, shall be discarded. [2] No milk, formula, or breast milk shall be warmed in a microwave oven.

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

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: _____