Medical Care Consent

I/we, _____, give the staff at Country Kids Child Care permission to administer medical care to my/our child, _____. I/we understand that it is my/our responsibility to ensure the staff are adequately educated and prepared to administer medical care. Also, I/we understand that should the condition of my/our child change in any way, the staff are allowed to contact Emergency Medical Services (EMS) for assistance and/or transport to a medical facility. Should the care required by my/our child change in any way the staff are to be notified and any training updated. I/we the parents/guardians agree to provide all medical supplies required for care. The Program Supervisor will ensure that only staff trained and capable of administering care will do so to ensure the safety and health of the child.

Family Doctor: _____ Contact #: _____

Specialist MD: _____ Contact #: _____

Surgeon: _____ Contact #: _____

Nurse: _____ Contact #: _____

Details of Care (include what, when and materials required):

_____

_____

_____

_____

_____

_____

_____

Name(s) of staff members trained and educated to provide medical care:

_____

_____

_____

Parent #1 Name: _____ Parent #1 Signature: _____

Date: _____

Parent #2 Name: _____ Parent #2 Signature: _____

Date: _____

Medical Care Consent

MEDICATIONS:

I/we, _____, give the staff at Country Kids Child Care permission to administer medication to my/our child, _____. I/we understand that it is my/our responsibility to ensure the staff are adequately educated and prepared to administer medications. Also, I/we understand that should the condition of my/our child change in any way, the staff are allowed to contact Emergency Medical Services (EMS) for assistance and/or transport to a medical facility. Should the medication required by my/our child change in any way the staff are to be notified and any training updated. I/we the parents/guardians agree to provide all medications required. I/we understand that the term medication is inclusive of any natural supplements, vitamins, over the counter and prescription drugs. The Program Supervisor will ensure that only staff trained and capable of administering medications will do so to ensure the safety and health of the child.

Please complete the contact information on the other side of this form before proceeding.

Name of Medication	Dates Required	Time	Dose (mg and mL)	Route	Reason	Comments

Name(s) of staff members trained and educated to administer medication(s):

_____

_____

_____

Parent #1 Name: _____ Parent #1 Signature: _____

Date: _____

Parent #2 Name: _____ Parent #2 Signature: _____

Date: _____