AUTHORIZATION FOR RELEASE

I, ____, authorize the following people to take my child from The Elaine Clark Center.

1. Name ____

   Address ____

   City _________________ State ______ ZIP ______________

   Home Phone _______________ Work Phone ______________

2. Name ____

   Address ____

   City _________________ State ______ ZIP ______________

   Home Phone _______________ Work Phone ______________

3. Name ____

   Address ____

   City _________________ State ______ ZIP ______________

   Home Phone _______________ Work Phone ______________

4. Name ____

   Address ____

   City _________________ State ______ ZIP ______________

   Home Phone _______________ Work Phone ______________

Signature ______________________________ Date ________________

Child Information Form

Child's Name________________________ **Date of Birth**_____________

Medical Concerns

____
____
____
____
____
____

Feeding Information (Check Everything Applicable)

Feeds Him/Herself _____
Hand over Hand Feed _____
Able to Finger Feed _____
Dependent on Caregiver for Feeding _____
Tube Fed _____

Drinks Independently from:
Open Cup _____
Sippy Cup _____
Needs Hand over Hand with:
Open Cup _____
Sippy Cup _____

Caregiver must hold cup _____
Adult fed from Bottle _____
Independently Bottle Feeds _____

Food Texture (Check Everything Applicable)

Tolerates and chews food of all textures _____
Tolerates and chews softly textured foods _____
Tolerates Softly Textured Food, but doesn't really chew _____
Needs food Pureed _____
Needs Liquids thickened _____
Has Difficulty Swallowing _____

Feeding Equipment (Check Everything Applicable)

Spoons
Uses Regular Tablespoon _____
Uses Burgundy Plastic Spoon_____
Uses White Plastic Spoon _____
Other __________________ _____

Cups
Uses Open Cup _____
Uses Sippy Cup _____
Uses Cup with Handles _____
Other________________ _____

Plates
Uses 3 Section plate _____
Uses Scoop Plate _____
Other ________________ _____

Seating
Sits in regular chair at table _____
Sits in Corner Chair _____
Sits in Rifton Chair _____
Other_________________ _____

Toilet Training (Check Everything Applicable)

Potty trained _____
Trip Trained (stays dry but doesn't indicate need to potty) _____
Uses Potty occasionally _____
Not ready for toilet training at this time _____

Equipment Needed (Check Everything Applicable)

Prone Stander	_____	AFO's	_____
Bench	_____	Hand Splints	_____
Wedge	_____	Wheelchair	_____
Corner Chair	_____	Walker	_____
Rifton Chair	_____	Cot	_____
Tumbleform Seat	_____	Mat	_____
Gait Trainer	_____	Side Lyer	_____
Other________________	_____		

Medical Concerns (Check Everything Applicable)

Allergies: ________________________________
____
____

Seizures

Child has not had seizures _____
Child has seizures on a regular basis _____
Unusual for child to have seizures at School _____

Reflux _____
Shunt _____

Is Child on Any Medication? Yes_____ No_____
What is medication for?
____
____
____

Miscellaneous

Does Child Take Naps?____

What toys does the child like?____
____
____
____

Does the child have special interests or favorite activities?_______________________
____
____

Does the child have any dislikes or fears?____
____
____

Favorite Foods?____
____
____

Food Dislikes?____
____
____

Nutritional supplements or special dietary restrictions?_____________________________
____
____

Does the child have any behavior issues?____
____
____

Religious Preference?____
____
____

Languages spoken in the home?____
____
____

What is the family's cultural identification?_____________________________________
____
____

What is your family structure?____
____
____

What terms are used to identify family members?__________________________________
____
____

Below you may list any additional information about your child and family that may …
____
____
____
____

Completed By:____

Date Completed:____

Permission for sunscreen/insect repellent

____
Child's name and date of birth

1. Before going outside, please apply: Sunscreen/insect repellent to
   Circle one or both

   ______________________________.

2. I am sending

   ____
   Please fill in the name of the preferred sunscreen/insect repellent
   for use on my child

3. I apply sunscreen/insect repellent before my child comes to the center so they do not need any applied at the center. Yes/No
   circle one

____
Signature

____
Relationship

____
Date

Permission for diaper cream/lotion

____
Child's name and date of birth

I give permission for the staff at Elaine Clark to apply

________________________________diaper cream

________________________________lotion

on my child as needed. I will provide the cream/lotion and it will not be shared with other children.

____
Signature

____
Relationship

____
Date

To: All Parents
From: Gayle Thompson, RN, CPN
RE: Medication Administration Policy for Elaine Clark Center

1. **Medications need to be given at home whenever possible**. If a medication is to be given twice a day your child can received it before coming to the center and after returning home. If the directions say to "give with food" then usually a few crackers or some milk or juice is enough to prevent stomach upset from the medicine. If a medicine is to be given three times a day, then a dose can be given at lunchtime at the center.

2. **Prescription medications** to be given at the center need to be in a bottle with the prescription label on it. We request that you ask your pharmacist for an empty bottle with the Rx label on it so the medicine may be divided and one bottle can stay at the center. Only **current** prescriptions may be administered with out a **written** note from the doctor. **If your child is being treated for a chronic condition, then we must have a statement from their doctor.**

3. **Over the Counter Medications** may not be given to children under **2 years** of age or 24 pounds without **written** permission from their doctor. Also note that many over the counter medications state "do not give to children under 6 years of age". I will also need written permission from the doctor to give these medications.

4. Medications are administered **only by the nurse between the hours of 8:30 am and 2:30 pm**. I must have a current permission slip on file (within the past 10 days) and written permission from the doctor if applicable to give any medication including over the counter medicine and vitamins.

5. **Please do not leave medicine** in your child's diaper bag. Medicines that are at the center that need to go home may be retrieved from the nurse's office at pick up time.

These are our general guidelines. Special medical needs are discussed on an individual basis.

We appreciate your understanding and cooperation with these policies.

5130 Peachtree Industrial Blvd ♦ Chamblee Georgia, 30341
phone(770)-458-3251 ♦ fax(770)458-3251

Permission for Prescription and non-prescription medicines to be given at Elaine Clark

Note: Children under 2 years old or 24 pounds need doctor's written permission to receive over the counter medicine

Prescriptions must be current unless there is a doctor's letter on file

Child's Name ______________________Date of Birth___________
Current Weight:___________ Allergies:______________________

Medication	Rx#	Dose	Time to give:	Time last given	Days to give:

Doctor Prescribing Medication: ________________________Phone number______________
Reason for Medication
____
____

I give my permission for the designated person(s) at The Elaine Clark Center to properly administer the above medication(s). If the medication order is changed, I will notify the center nurse/director immediately.

______________________________ ____________________________
Signature Date

____
Relationship

This form must be renewed every TEN DAYS unless the child is being treated for a chronic condition. If a chronic condition is being treated, we must have a letter from your child's doctor.

Rev 5/06 GT

Physicians Statement
Medication administration or special procedure at school

Date ____________________ Expiration of order date __________________

Name of Student _______________________________________DOB_______________

Medication / formula	Dose	Route	Time to give	Reason for

Possible significant side effects____

Note: The first does of any new medication may not be given at school.

Special Procedure

____
____
____
____

_________________________________ ___________________________________

Physician Signature Physician's printed name

_________________________________ ___________________________________

Physician phone number Physician's address

I give my permission for my child _________________________________ to receive the above medication(s) / procedure(s) at the center as written above.

Date:________________________ Parent/guardian signature:_____________________________

All medications must be in an original container with current prescription label.

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