Medical Emergency/Contact List/Consent Information

Child_____________________________Birthdate_______________

Primary Contact___________________________Phone(s)_____________________________
Secondary Contact_________________________Phone(s)_____________________________

Regular Medication(s)____
Time(s) administered____
Allergies____
____
Reactions/symptoms____
____
Previous illness/hospitalizations____
Other health concerns____
____

______
(Initial)

EMERGENCY MEDICAL CARE

This authorizes Learning Connections of Galesburg to secure EMERGENCY medical care for my child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. I understand first aid will be administered by staff responsible for my child/ren.

______
(Initial)

ADMINISTER PRESCRIPTION AND/OR PATENT MEDICINE

I/We authorize Learning Connections of Galesburg to administer medicine prescribed by a physician to my child as specified in the prescription's directions for administration. I/We understand there will need to be a "Request to Administer Medication" form on file for each new medication prescribed. Medication will be administered by the director or another trained staff in accordance with our Medication Policy. The Medication Policy is in our family handbook.

Physician's Name: ______________________ Address: _______________________________ Phone: _________________________________	Preferred Hospital or Clinic: ____

______
(Initial)

EMERGENCY CONTACTS / CHILD PICK UP

I/We authorize ONLY the following people to pick up my child(ren) in case of emergency **when I/we are unavailable.** I understand they will be asked to show a photo ID when picking up.

Name	Address	Phone	Relationship to Child

______ **PARENT HANDBOOK/POLICIES**
(Initial) I/We have received, read and understand the policies set forth in the parent handbook.

______ **TRIPS, EXCURSIONS, AND PUBLC PARK FACILITIES**
(Initial) I/We authorize Learning Connections of Galesburg to take my/our child on walking trips, special excursions and to nearby public park facilities. I understand that these trips will be under the supervision of Learning Connections of Galesburg staff and all possible precautions will be taken to ensure the health and safety of my/our child in compliance with DCFS standards for licensure. I understand that these trips may be in a vehicle owned or leased by the center.

______ **PHOTOGRAPHS**
(Initial) I/We authorize Learning Connections of Galesburg to use photographs of the above named child(ren) for purposes of publicity, advertising, or general interest (i.e. newspaper stories).

______ **RELIGION**
(Initial) I/We understand that Learning Connections of Galesburg is founded on Christian principles. The Christian meaning of Christmas and Easter will be celebrated. Children may also say or sing a simple prayer before snacks and/or lunch.

MISCELLANEOUS

______ (Initial) I understand that all soiled clothing items belonging to my child are required to be bagged and sent home. Center personnel are NOT allowed to rinse soiled clothing.

_____ (Initial) I understand my child will not be allowed to attend if he/she is ill. The guidelines for exclusion from care are outlined in the Family Handbook.

_____ (Initial) I understand Learning Connections practices Integrated Pest Management. I understand pesticides are used only after preventative techniques and non-chemical measures have been taken. I **do not** wish to written notification each time pesticide application is necessary.

_____ (Initial) I understand that my child may need to move to another classroom at the beginning or end of each day to accommodate safe and licensing compliant staffing patterns.

_____ (Initial) I agree to sign my child in/out on the computer as well as classroom forms each day. I will accompany my child to his/her classroom, washing hands upon arrival. I will make contact with the teacher upon arrival and departure.

_____ (Initial) I understand personal belongings should be labeled with my child's full name.

_____ (Initial) I am aware of the Department of Children and Family Services' right to interview the child and LCG staff, to inspect and audit all records maintained by the school, to observe the physical condition of the child, and to have a licensed medical professional physically examine the child without securing my prior consent.

____ ________________________

Signature of Primary Contact Date