

## REPORT YOUR CONCERNS

If you have any concerns that your family child care provider is not operating according to State regulations, do something about your concern immediately. If possible, try to resolve your concern directly with your provider. If this is not possible, or if after you have talked to your provider, your concerns remain, call your sponsoring organization or the Office of Licensing. Your name will remain confidential upon request.

## IMPORTANT CONTACTS

Parents may contact their local sponsoring organization for information regarding referrals for child care, information on other community resources available for parents and children and any questions regarding family child care.

**Your local sponsoring organization is:  
Child Care Resources  
PO Box 1234, Neptune, NJ**

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- To report child/abuse neglect, call the DHS Child Abuse/Neglect Hotline: toll-free at **1-877-NJABUSE** or **1-877-652-2873**
- Parents may obtain information about child abuse and neglect by contacting the Department of Children and Families, Office of Communications and Legislation at 609-292-0422. Requests are accepted by e-mail at [dcf.publications@dcf.state.nj.us](mailto:dcf.publications@dcf.state.nj.us), or by fax to 609-984-2123. Some publications may be downloaded at <http://www.nj.gov/dcf/news/publications>.
- To secure a copy of the Manual of Requirements for Family Child Care Registration, write or telephone your local sponsoring agency at **732-918-9901**
- To report alleged violations of the Manual of Requirements for Family Child Care Registration, call your local sponsoring agency at **732-918-9901** or call the Office of Licensing toll -free at **1-877-667-9845**

## INFORMATION TO PARENTS

## ABOUT

## FAMILY CHILD CARE REGISTRATION



## Information to Parents about Family Child Care Registration

Under the provisions of the Manual of Requirements for Family Child Care Registration (N.J.A.C. 10:126), every family child care provider in New Jersey is required to supply each parent of an enrolled child with this *Information to Parents Statement* that has been supplied to a provider by the sponsoring organization in this area. (See last page for the name, address, and telephone number of your sponsoring organization). In keeping with this requirement the provider must secure every parent's signature attesting to his/her receipt of this information.

- A registered family child care provider has received a Certificate of Registration. The provider's Certificate of Registration must be posted in a prominent location within the family child care home during operating hours.
  - To be registered, a provider must comply with the Manual of Requirements for Family Child Care Registration, the official registration regulations. The regulations cover such areas as physical environment, safety, provider qualifications, health, program, food and nutrition, supervision, rest and sleep requirements and others.
  - Parents may receive a copy of the Manual of Requirements for Family Child Care Registration by contacting the sponsoring organization.
  - Parents may report alleged violations of the Manual of Requirements for Family Child Care Registration to the sponsoring organization or to the Office of Licensing.
  - Any person who has reasonable cause to believe that a child enrolled in the family child care home has been or is being subjected to any kind of child abuse/neglect by any person, whether in the family child care home or not, is required by State law to report such allegations to the DHS Child Abuse/Neglect Hotline: Toll-Free at 1-877-NJABUSE or 1-877-652-2873.
- Parents of enrolled children shall be permitted to visit the family child care home at any time when enrolled children are present without having to secure the prior approval of the provider. Parents may be restricted to visit only those areas of the home designed for family child care.
  - The operation of the family child care home is subject to monitoring by the sponsoring organization at least once every two years and by the Department of Human Services.
  - The provider is required to comply with the inspection/investigation functions of the sponsoring organization and the Department, including the interviewing of adults and children in the family child care home.
  - Parents may request that the sponsoring organization provide technical assistance to the parent or the provider, and referrals, and referrals to appropriate community resources.
  - When an enrolled child has been identified as or is suspected of having a developmental delay or disability, the sponsoring organization shall:
    1. Inform the parent of the child's right to early intervention and special education services, if eligible;
    2. Refer the parent to the New Jersey Department of Education Project Child Find at **1-800-322-8174** (toll-free) for a comprehensive evaluation and development of an individual service plan for the child, as appropriate; and
    3. Refer the parent to the New Jersey Department of Health and Senior Services Special Child Health Services Program at **(609) 292-5676** for a possible comprehensive medical evaluation for the child.

**Parents' Signature form for**  
**Receipt of Information to Parents Statement**

Name of Provider:

\_\_\_\_\_

I have received a copy of the *Information to Parents Statement* from my family day care provider.

Name of Child/Children:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent's Signature: \_\_\_\_\_

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

## Family Child Care Parent-Provider Agreement

**Parents:**

My child \_\_\_\_\_ will  
(child's name)  
begin to receive family child care services from \_\_\_\_\_  
\_\_\_\_\_  
(provider's name)  
at \_\_\_\_\_  
(address)  
on \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_.  
(date) (time) (time)

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

The fee for service will be \$ \_\_\_\_\_ per \_\_\_\_\_ payable  
\_\_\_\_\_ week(s) in advance beginning on \_\_\_\_\_.  
Payment will be made every \_\_\_\_\_.

As a parent enrolling my child in family child care, I agree to:

- Inform the provider of my home and work addresses and telephone numbers.
  - Arrange for an emergency contact to pick up my child in the event I can not be reached.
  - Notify the provider if my child can not be picked up or dropped off at the regular time.
  - Inform the provider if someone other than parents will pick up my child.
  - Give the provider an up-to-date immunization record and physician's examination statement for my child.
  - Inform the provider if my child contracts a contagious disease.
  - Pick up my child immediately if notified that she/he is ill.
  - Maintain the following articles of clothing in the child care home at all times
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- Supply additional items listed below

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- I understand that a late fee of \$ \_\_\_\_\_ per \_\_\_\_\_, payable on the next child care day, will be charged if I am late picking up my child.
- I also agree to the following

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**Providers:**

As your child's family child care provider, I agree to:

- Discuss your child's daily activities and routines with you.
- Provide a safe, healthy, stimulating environment for your child.
- Inform you of the name of the substitute provider who will care for the children in my absence.
- Inform you about any pets in my home.
- Permit you to visit my home at any time when enrolled children are present.
- Inform you about my policy regarding the admission of sick children to my home and the administration of medication to children.
- Notify you immediately if your child is seriously injured, or by the end of the day if the injury is not serious. I will give you a written accident report by the end of the next working day.
- Obtain your written permission before transporting you child.
- Obtain your written permission before permitting your school-age child to leave my direct supervision.
- Give you a copy of the Information to Parents statement given to me by my sponsoring organization.
- Inform you that you may request the sponsoring organization to provide technical assistance or referral to appropriate community resources. My sponsoring organization is:

Child Care Resources  
P.O Box 1234  
Neptune, NJ 07753  
(732) 918-9901

- I also agree to the following

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My family child care program will be closed for the following holidays:

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<hr/>	<hr/>
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<hr/>	<hr/>
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Payment arrangements when my program is closed:

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Payment arrangements when my program is open and your child is absent:

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Signature of parent(s):

<hr/>	<hr/>	Date
(print)	(sign)	
<hr/>	<hr/>	Date
(print)	(sign)	

Signature of provider:

<hr/>	<hr/>	Date
(print)	(sign)	

## Child's Admission Record

Today's Date: \_\_\_\_\_ Date of Enrollment: \_\_\_\_\_

### Child's Information:

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name by which child is most often called:

Home Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### Father's Information:

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

Home Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Days and Hours of Employment: \_\_\_\_\_

### Mother's Information:

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

Home Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Days and Hours of Employment: \_\_\_\_\_

### Emergency Contacts:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

### Child's Doctor:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### Child's Dentist:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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For Provider's Use Only: Date of Withdrawal: \_\_\_\_\_

**Emergency Treatment Information and Authorization**

I, (name of parent) \_\_\_\_\_, agree to the administration of emergency medical treatment to my child, (name of child) \_\_\_\_\_, by a duly qualified health practitioner in my absence. I authorize, (name of provider) \_\_\_\_\_, to arrange for such emergency medical treatment until such time as I can be present.

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

(Sign in Presence of Notary) Date: \_\_\_\_\_

To be Filled in by Notary Public:

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

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

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What, if any, illness has your child had in the past month?

\_\_\_\_\_

Is your child currently taking any type of medication? (circle one)      Yes      No

If yes, explain:

\_\_\_\_\_

What, if any, allergies does you child have?

\_\_\_\_\_

List any chronic or handicapping problems your child has, such as seizures, asthma, diabetes, heart disease, or respiratory illness:

\_\_\_\_\_

Parent's hospitalization insurance or medical assistance plan:

Carrier: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Policy is in name of: \_\_\_\_\_

## Family Information

Person(s) designated to pick up child other than parent(s):

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Person(s) specifically not permitted to pick up child:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Language(s) spoken in the home: \_\_\_\_\_

List other children in the family:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

List other adults living in your home:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

List pets living in you home:

Name: \_\_\_\_\_ Type: \_\_\_\_\_

Name: \_\_\_\_\_ Type: \_\_\_\_\_

Name: \_\_\_\_\_ Type: \_\_\_\_\_

List previous experience in day care, including name of facility, dates attended, and type of care (such as family day care, day care center, nursery school, nanny etc...):

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# UNIVERSAL CHILD HEALTH RECORD

Endorsed by:  
American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health and Senior Services

SECTION I: TO BE COMPLETED BY PARENT(S)			
Child's Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)	
		Height (must be taken within 30 days for WIC)	
		Head Circumference (if <2 Years)	
		Blood Pressure (if ≥3 Years)	
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:	

MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

## Instructions for Completing the Universal Child Health Record (CH-14)

### Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

### Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
  - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
  - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
  - **Head Circumference** - Only enter if the child is less than 2 years.
  - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
  - The Immunization record must be attached for the form to be valid.
  - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care setting.
  - a. **If the child has a complex medical condition, a special care plan should be completed and attached.** Note any significant medical conditions or major surgical history.
  - b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care. (seizure, cardiac or asthma medications etc.) Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may likely require separate permissions slips for prescription and OTC medications.*
  - c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
  - d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
  - e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at [www.pacnj.org](http://www.pacnj.org) or by phone at 908-687-9340.
  - f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
  - g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
  - h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
  - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
  - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
  - Scoliosis screenings are done biennially in the public schools beginning at age 10.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
  - Print the health care provider's name.
  - Stamp with health care site's name, address and phone number.

## Personal Information Record for Infants/Toddlers

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

1. What is your child's current daily sleeping schedule?  
Morning Wake-up Time: \_\_\_\_\_ Evening Bedtime: \_\_\_\_\_  
Daily Naps: \_\_\_\_\_
2. Is your child sleeping through the night? \_\_\_\_\_  
If not, when does child usually wake up at night? \_\_\_\_\_
3. What upsets or frightens your child? \_\_\_\_\_  
\_\_\_\_\_
4. What does your child find soothing or comfortable? \_\_\_\_\_  
\_\_\_\_\_
5. How is your child now reacting to strangers? \_\_\_\_\_  
\_\_\_\_\_
6. Is your child using a cup, a bottle or both? \_\_\_\_\_
7. Are you breast feeding you child?      Yes      No  
If yes, at what times? \_\_\_\_\_
8. What are the times your child is receiving the bottle each day? \_\_\_\_\_  
\_\_\_\_\_
9. Give the number of ounces your child is now taking at each bottle feeding?  
\_\_\_\_\_
10. Is your child taking formula, whole milk, skim milk or other? \_\_\_\_\_
11. Give any special instructions for preparing formula, if any? \_\_\_\_\_  
\_\_\_\_\_
12. Are there any other special instructions concerning bottle feeding you child?  
\_\_\_\_\_
13. Is your child now on baby food or table food? \_\_\_\_\_
14. List foods your child is now eating:  
Vegetables      Fruits      Meats      Juices      Breads

15. Is your child now eating finger foods?    Yes                  No

If yes, please list:

\_\_\_\_\_

16. Where does your child spend her/his waking hours? \_\_\_\_\_

17. What toys and activities make her/him happy? \_\_\_\_\_

18. When does your child usually have bowel movements? \_\_\_\_\_

19. Has your child begun potty training?                  Yes                  No

If yes, describe her/his routine?

\_\_\_\_\_

20. What does your child call her/his:

Bowel Movement: \_\_\_\_\_ Urination: \_\_\_\_\_

21. This space is for any other information you wish to share about your child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parents Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Personal Information Record For School Age Children

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

As a parent, you can assist me in planning for your child's stay in my home by sharing the following information:

1. What does your child usually prefer to do after arriving home from school?

\_\_\_\_\_

2. What are your child's favorite snacks?

\_\_\_\_\_

3. Does she/he have a strong dislike for certain foods?

Are there any foods your child is not permitted to eat? (Explain)

\_\_\_\_\_

4. Do you wish to have your child complete homework assignments while in my care?

\_\_\_\_\_

5. Would you prefer to balance some active play with completing homework assignments?

\_\_\_\_\_

6. Do you wish to have your child participate in any activities away from my home? (Describe)

7. Describe arrangements for transporting your child, if any. (Please be aware that I require your written permission to allow your child to leave my direct supervision while in my family day care program.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. State regulations require that television be used with discretion for program activities in the family day care home. I plan to allow a limited time for television viewing. Please share your recommendations for appropriate television programs for your child.

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9. Does your child have permission to phone her/his parent's place of business?

Yes      No

If yes, what time(s) may child call?

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Do these calls require a toll charge?      Yes      No

If yes, will the family day care home be reimbursed for these toll calls?

Yes      No

Do you wish to limit the number and length of phone calls your child makes and receives?

(Explain limitations)

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10. Does your child have any hobbies or special interests?

11. This space for any additional comments:

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School Child Attends: \_\_\_\_\_

Grade: \_\_\_\_\_ School Telephone Number: \_\_\_\_\_

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

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

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Sample Medication Permission Form

Child's Name: \_\_\_\_\_

Name of Medication(s): \_\_\_\_\_

Prescription       Non-prescription       Doctor's Approval Required

Amount to be Administered: \_\_\_\_\_

Times to be Administered: \_\_\_\_\_

Refrigeration Necessary :  Yes       No

Possible Adverse Reactions: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Date and Time(s) Administered:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adverse Reactions Observed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Injury and Accident Report

Name of Child: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

Child's Phone Number: \_\_\_\_\_

Nature of Injury (describe in detail, including how it happened):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names of Witnesses: \_\_\_\_\_

First-Aid Care Administered:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Administered by: \_\_\_\_\_ Time: \_\_\_\_\_

Physician notified, if any: \_\_\_\_\_ Time: \_\_\_\_\_

Ambulance called, if any: \_\_\_\_\_ Time: \_\_\_\_\_

Where Directed: \_\_\_\_\_ Time: \_\_\_\_\_

Which parent was notified (or guardian): \_\_\_\_\_ Time: \_\_\_\_\_

Provider's Signature:

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

Parent's Signature:

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

