

**St. Ursula School/Extended Day Program**  
**8900 Harford Road**  
**Baltimore, Maryland 21234**  
**410-665-3533**

May 2019

Dear Parents,

Below are the new rates for before and after care. All current school families who are intending to use Extended Day **must register** for next year no later than **May 15, 2019**. Extended Day will begin September 4, 2019. ***If you do not register by May 15 you will not be able to start until September 16<sup>th</sup>***. Registration information is attached and can also be found on the school website ([www.stursula.org](http://www.stursula.org)) under the "Admissions" tab. Please return all forms in an envelope marked "Niki – Extended Day."

Sincerely,

Debbie Glinowiecki  
Principal

Niki Thoeicht      Suzanne Wood  
Extended Day Co-Directors

**SAINT URSULA SCHOOL EXTENDED DAY  
INFORMATION SHEET**

**Hours of Operation:**

7:00 a.m. – 7:45 a.m.

2:50 p.m. – 6:00 p.m.

**Registration Fees**

Registration fees are non-refundable

One child	\$20.00
Two children	\$30.00
Three or more children	\$35.00

**Current Fees Beginning September 2018:**

AM:            \$7.00 per morning            \$28.00 per week

PM:            \$12.00 per afternoon            \$50.00 per week

AM & PM:    \$70.00 per week

2019-2020

St. Ursula School Extended Day  
Registration

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

So that we may bill correctly, please check the time(s) that best suit your needs. You may choose a different option for morning and afternoon.

**Morning:**            \_\_\_\_\_ Full Time            \_\_\_\_\_ Part Time

**Afternoon:**        \_\_\_\_\_ Full Time            \_\_\_\_\_ Part Time

Billing is handled as follows:

Full Time: You will be billed at the beginning of the month for daily attendance. This option is for parents who will be using Extended Day on a daily basis.

Part Time: You will be billed at the end of the month for only the days your child is in attendance. This option is for parents who will not be using Extended Day on a daily basis.

\_\_\_\_\_ I have read the *Guide to Regulated Child Care* that was included with this registration packet.

Attached is my non-refundable registration fee made payable to Saint Ursula Extended Day.

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

**SAINT URSULA EXTENDED DAY  
AUTHORIZATION FORM**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

The following people are authorized to sign out my child(ren) from Saint Ursula Extended Day Program. Please have the person(s) listed below bring a photo ID. Please include all parents/guardians.

1. Parent/Guardian (please print) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

2. Parent/Guardian (please print) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

List below others who are eligible for pick-up other than parent/guardian

\* \* \* \* \*

3. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

4. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

5. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

6. Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

**EXTENDED DAY HEALTH QUESTIONNAIRE  
2019-2020**

**\*\*Please complete one form in full for each child being registered.**

Student Name and Grade: \_\_\_\_\_

Parent Contact Information: \_\_\_\_\_

Mother: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Father: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

1. Does your child have any medical conditions which should be brought to our attention:

No \_\_\_\_\_

Yes \_\_\_\_\_ (If yes, please complete #2)

2. If yes, please list below information regarding your child's condition. An Extended Day staff member will contact you to follow up regarding treatment, medication, additional required paperwork, etc. If additional space is needed, please continue on a separate sheet of paper.

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**For questions, concerns or to file a complaint contact your regional office**

Anne Arundel	410-573-9522
Baltimore City	410-554-8315
Baltimore County	410-583-6200
Prince George's	301-333-6240
Montgomery	240-314-1400
Howard	410-714-0500
Western Maryland, Allegany, Garrett & Washington	301-328-2200
Upper Shore, Kent, Dorchester, Talbot, Queen Anne's & Caroline	410-326-2200
Lower Shore, Wicomico, Somerset & Worcester	410-326-2200
Southern Maryland, Calvert, Charles & St. Mary's	800-442-2200
Harford & Cecil	410-408-4578
Frederick	301-694-9766
Carroll	410-549-6489

The OCC Regional Office will investigate your complaint to determine if child care licensing regulations have been violated. All confirmed complaints against child care providers may be viewed at [CheckCCMD.org](http://CheckCCMD.org).

For additional help, you may contact the Program Manager of the Licensing Branch at 410-569-8071.

**Resources**

**Child Care Subsidy** - Assists parents with cost of childcare  
 1-866-243-8796

**Consumer Product Safety Commission (CPSC)** - regulates certain products used in childcare  
[CPSC.GOV](http://CPSC.GOV)

**Maryland EXCELS** - Maryland's Quality Rating System for Childcare Facilities  
[www.marylandexcls.org](http://www.marylandexcls.org)

**Maryland Developmental Disabilities Council** - May assist with ADA issues  
[www.mddc.org](http://www.mddc.org)

**Maryland Family Network** - Assists parents in locating childcare  
[www.familynetwork.org](http://www.familynetwork.org)

**Child Care Management**  
[www.childcaremanagement.org](http://www.childcaremanagement.org)

**PARTNERS Newsletter** - What's happening in the Division of Early Childhood Development  
[earlychildhood.marylandpublicchildcare.org](http://earlychildhood.marylandpublicchildcare.org)

**Early Childhood Public Maryland**  
[www.earlychildhoodpublicmd.org](http://www.earlychildhoodpublicmd.org)

To this site to check provider inspection violations

[checkccmd.org](http://checkccmd.org)



Larry Hogan, Governor

Karen B. Salmon, Ph.D.

State Superintendent of Schools

OCC 1524 (10/2018)

# Guide to Regulated Child Care



**Important Information About Child Care Facilities**

## Who Regulates Child Care?

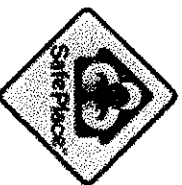
All child care in Maryland is regulated by the Maryland State Department of Education, Office of Child Care's OCC), Licensing Branch.

The Licensing Branch's thirteen Regional Offices are responsible for all regulatory activities, including:

- Issuing child care licenses and registrations to child care facilities that meet state standards;
- Inspecting child care facilities annually;
- Providing technical assistance to child care providers;
- Investigating complaints against regulated child care facilities;
- Investigating reports of unlicensed (illegal) child care; and
- Taking enforcement action when necessary.

Child care regulations are available at <http://www.marylandpublicschools.org/child-care-providers/office-child-care>.

State child care regulations are found at <http://www.marylandpublicschools.org/child-care-providers/office-child-care>.



## What are the Types of Child Care Facilities?

### Did You Know?

**Family Child Care** – care in a provider's home for up to eight (8) children

**Large Family Child Care**– care in a provider's home for 9-12 children

**Child Care Center** – non-residential care

**Letter of Compliance (LOC)** – care in a child care center operated by a religious organization for children who attend their school

#### All facilities must meet the following requirements:

- Must obtain the approval of OCC, fire department and local agencies;
- Must have qualified staff who have received criminal background checks, child abuse and neglect clearances, and are not on the sex offender registry;
- Family child care providers must maintain certification in First Aid and CPR;
- Child Care Centers must maintain a ratio of one staff certified in first aid and CPR per every twenty (20) children at all times;
- Must offer a daily program of indoor and outdoor activities;
- Must maintain a file with all required documentation for each enrolled child;
- Must post approved evacuation plans, conduct fire drills and emergency preparedness drills; and
- Must report suspected abuse and neglect, and may not subject children to abuse, neglect, mental injury or injurious treatment.

- Regulations that govern child care facilities may be found at: <http://www.marylandpublicschools.org/regulations>

- The provider's license or registration must be posted in a conspicuous place in the facility;

- A child care provider must enter into a written agreement, with a parent, that specifies fees, discipline policy, presence of animals, the use of volunteers, and sleeping arrangements for overnight care;

- Parents/guardians may visit the facility without prior notification any time their children are present;

- Written permission from parents/guardians is required for children to participate in any and all off-property activities;

- All child care facilities must make reasonable accommodations for children with special needs;

- A "Teacher" qualified person must be assigned to each group of children in a child care center;

- Staff:child ratios must be maintained at all times in child care centers;

- Parents/guardian must be immediately notified if children are injured or have an accident in care;

- Child care facilities may have policies beyond regulatory requirements;

- OCC should be notified if a provider has violated child care regulations;

- Parents/guardians may review the public portion of licensing file; and

- The provider's compliance history may be reviewed on [CheckCMD.org](http://CheckCMD.org).

## EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

**NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____	C: _____	H: _____
		W: _____		
		Place of Employment: _____	C: _____	H: _____
		W: _____		

Name of Person Authorized to Pick up Child (daily) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES** \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

2. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

3. Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

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

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number



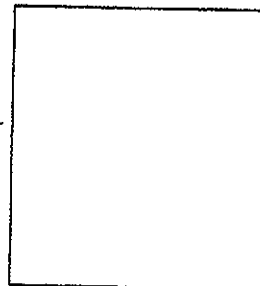
# All students if applicable

MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: \_\_\_\_\_

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Parent/Guardian must bring the medication to the facility.
- Must pick up the medication at the end of authorized period, otherwise it will be discarded.



Child's Picture (Optional)

### PRESCRIBER'S AUTHORIZATION

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

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_ (PRN=as needed)

Possible side effects & special instructions: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

Known Food or Drug: Allergies? Yes No If Yes, please explain \_\_\_\_\_  
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: \_\_\_\_\_  
(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

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

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

### PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.

Prescriber's authorization: \_\_\_\_\_  
Signature Date

Parental approval: \_\_\_\_\_  
Signature Date

Signature Date

### FACILITY RECEIPT AND REVIEW

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received:  YES  NO

Medication was received by: \_\_\_\_\_  
Signature of Person Receiving Medication and Reviewing the Form Date

All students if applicable

MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
Seizure Medication Administration Authorization Form

Name of Child Care Facility \_\_\_\_\_

This form authorizes emergency seizure care for \_\_\_\_\_  M  F  
(Child's Name) (Date of Birth)

while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician \_\_\_\_\_ Phone# \_\_\_\_\_ # After Hours \_\_\_\_\_

Significant Medical History: \_\_\_\_\_

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: \_\_\_\_\_

Seizure Emergency Protocol (Check all that apply and clarify below)

Call 911 for transport to \_\_\_\_\_  Notify parent or emergency contact  
 Notify treating physician \_\_\_\_\_  Other \_\_\_\_\_

Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure?  Yes  No If YES, describe process for returning the child to the classroom. \_\_\_\_\_

Special Considerations and Precautions (regarding activities, sports, trips, etc.) \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

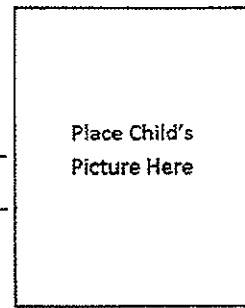
**Parent Information & Authorization:** Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

All students if applicable

**Allergy Action Plan**

Must be accompanied by a Medication Authorization Form (OCC 1216)



CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Is the child Asthmatic?  No  Yes (If Yes = Higher Risk for Severe Reaction)

**TREATMENT**

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger: But is <i>not</i> exhibiting or complaining of any symptoms	Give this Medication	
	Epinephrine	Antihistamine
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

\*Potentially life-threatening. The severity of symptoms can quickly change.  
 \*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication	Dose:
Epinephrine:	
Antihistamine:	
Other:	

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY CALLS**

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Contact(s)	Name/Relationship	Phone Number(s)	
		Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

\*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self-Carry Self Administration  
 I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only]  Yes  No

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

All students if applicable

### Allergy Action Plan (Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's  
Picture Here

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Is the child Asthmatic?  No  Yes (If Yes = Higher Risk for Severe Reaction)

**The Child Care Facility will:**

- Reduce exposure to allergen(s) by: (no sharing food, \_\_\_\_\_)
- Ensure proper hand washing procedures are followed. \_\_\_\_\_
- Observe and monitor child for any signs of allergic reaction(s). \_\_\_\_\_
- Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) \_\_\_\_\_
- Ensure that a person trained in Medication Administration accompanies child on any off-site activity. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Call 911**

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit [epipen.com](http://epipen.com).

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**The Parent/Guardian will:**

- Ensure the child care facility has a sufficient supply of emergency medication.
- Replace medication prior to the expiration date
- Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

All students if applicable

Maryland State Child Care/Nursery School  
 Asthma Medication Administration Authorization Form  
 ASTHMA ACTION PLAN for \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (not to exceed 12 months)



Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ PEAK FLOW PERSONAL BEST: \_\_\_\_\_

Triggers (list)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ASTHMA SEVERITY:  Exercise Induced  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE			
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication Dose Route Frequency		
<input type="checkbox"/> Prior to exercise/sports/ physical education <b>YELLOW ZONE: Quick Relief Medications</b> to be added to Green zone medications for symptoms <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-75% personal best)	Medication Dose Route Frequency	If using more than twice per week for exercise, notify the health care provider and parent/guardian. If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.	Medication Dose Route Frequency
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or skin retracts between ribs <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	Medication Dose Route Frequency	Contact the parent/guardian after calling 911.	

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

(School-age children)  Yes  No  
 Prescriber signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Child Care Provider: Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 3/20/2014