Jin-A Child Care Center
77 Jay Street, Clifton, NJ 07013
Tel: 973-279-1203, Fax: 973-279-0126
E-mail: jinaschool@verizon.net Web: www.jinaschool.com

April, 2024

Dear Parents!

It is time to re-register for the new school year!
Please re-register ASAP or by May 1st, before we open up registration to the general public. Spots fill up quickly.

As a NJ state licensed center, the following items are required for registration:

1. Please find enclosed the revised tuition schedule for the 2024-25 school year, effective September 1, 2024.
2. Please send a $100 registration fee to secure a space for the new school year.
3. If any information has changed (enrollment days, phone #s, emergency contacts, pick up person, doctor), please fill out the Registration Form and return it with a $100 registration fee.
4. Please read the Family Handbook and policies which are posted on our website. A hard copy is available at the Jin-A office.
5. Your child's Universal Health Record has to be renewed. (Records must have been signed in the last 6 months.)
6. Emergency medication Plan has to be renewed. (optional)
7. If your child has Asthma / Food Allergies Action Plan, please update. (Need to renew annually.) Don't forget to sign the Medication Authorization for each medication.
8. If you are not planning to re-register your child, please call / e-mail the office to avoid additional charges.
9. **Dues date is Mayl 1st**.

Thank you for your patronage and entrusting your children to our care. If you have any questions please do not hesitate to call/email us.

Jin-A Office

Jin-A Pre-K Calendar
2024-2025

Tel: 973-279-1203 Fax: 973-279-0126
E-Mail: jinaschool@verizon.net
Web: www.jinaschool.com

September 2024

Su	Mo	Tu	We	Th	Fr	Sa
1	~~2~~	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 2024

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 2024

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	~~28~~	~~29~~	30

December 2024

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	~~25~~	~~26~~	~~27~~	28
29	30	31				

January 2025

Su	Mo	Tu	We	Th	Fr	Sa
			~~1~~	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	~~17~~	18	19	20	21	22
23	24	25	26	27	28	

March 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 2025

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	~~18~~	19
20	21	22	23	24	25	26
27	28	29	30			

May 2025

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	~~26~~	27	28	29	30	31

June 2025

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July 2025

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	~~4~~	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August 2025

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~
~~24~~	~~25~~	~~26~~	~~27~~	~~28~~	~~29~~	~~30~~
~~31~~	~~9/1~~	9/2	9/3	9/4	9/5	9/6

Sep. 2 ..... Labor Day (closed)
Sep. 3 ..... First Day of School
Nov. 28, 29 ..... Thanksgiving Recess (closed)
Dec. 25, 26, 27.. Christmas Day off (closed)
Jan. 1 ..... New Year's Day off (closed)
Jan. 2 ..... School Re-opens
Feb. 17 ..... President's Day (closed)
(Teachers Training)

Apr. 18 ..... Good Friday (closed)
May 26 ..... Memorial Day (closed)
Jun.13 ..... Graduation
Jun.13 ..... Last day for 10 month Program
Jul. 4 ..... Independence Day
Aug. 18 ~ Sep. 1. Teachers Training (closed)
Sep 2..... First Day of New School Year

(This includes 4 snow days that need not be made up)

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TUITION SCHEDULE

Effective September 2024

Pre-School

Registration Fee: $100 per year

Weekly Tuition:

Full Day (9:00-5:00) 8 hours			Half Day (9:00-1:00) 4 hours		
	Over 2.5 years	Under 2.5 years		Over 2.5 years	Under 2.5 years
5 days / week	$315	$ 345	5 days / week	$265	295
4 days / week	295	315	4 days / week	250	275
3 days / week	265	290	3 days / week	230	255
2 days / week	230	250	2 days / week	210	235

* Flexible hours can be arranged through the office.
* Billed every two weeks

Drop-in Rate: $120 /day (must be approved by the office)

Kindergarten

Registration & Book Fee: $175 per year

Yearly Tuition:

School Hours (9 am - 3 pm)	$8,900 (Sep-May $935 / month, June $485)
Extended Day (9 am - 5 pm)	$9,900 (Sep-May $1,035 / month, June $585)

After School / Holiday Care Drop-in: $13 /hour, $100 /day (must be approved by the office)

Extended Care

Early care (7:30-9:00 am) and late care (5:00-6:00 pm) can be scheduled through our office.

Early Care or Late Care: $20 /week, $5 /day
Early and Late Care combined: $30 /week, $10 /day

Drop-in Extended Care (without registration)

Early Care or Late Care: $10 /day

☆ **Sibling discount** is available for second child. ($20 off weekly 5 full day tuition)
☆ Rates include **4 snow (emergency) days** that need not be made up.
☆ Please notify our office of any enrollment changes **two weeks in advance.**
☆ There is **no refund or make up** of missed days in case of **illness or holiday closing**.
☆ There are **no adjustments for short** (less than two weeks) **absences**. For **more than two weeks** absences you can **pay half of your tuition** and we will keep the spot for you. Please provide two weeks advance notice in writing.
☆ Additional fees will be charged beginning at 5:15 pm, if you are not registered for late care. If you are registered for late care, an additional fee will be charged if pick up is after 6:00 pm.
☆ A parent who has to **withdraw** a child from Jin-A before the school year finishes should give **written notice to the Director four weeks in advance**. Parents are **responsible for four weeks' tuition** after the day of notification.
☆ After **five working days past due**, there is a **late fee** of **$10.00**. After ten days, the **late fee** is **$20.00**. After four weeks of delayed payment, the child will not be able to attend Jin-A Child Care Center until all past due and present fees have been paid. Any outstanding tuition bill after two months of termination will be collected by a collection agency at your cost.

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Registration Form

Child's Name_____ Sex_____

Birth Date_____ Ethnicity_____ Rel. Affiliation_____

Home Address _____ Home Phone_____

_____

E-Mail Addresses _____ _____

Father's Name (Legal Guardian)_____Work Phone_____
Company Name _____Cell Phone_____
Address _____

Mother's Name (Legal Guardian)_____Work Phone_____
Company Name _____Cell Phone_____
Address_____

Person authorized to assume responsibility for the child if parent is not available
Name_____ Relationship with family_____
Home Phone_____ Work Phone_____ Cell Phone_____

Child's Doctor_____Phone_____
Address_____

Other children in your family
Name Date of Birth Sex
_____
_____

Enrollment (circle) Year round program 10 Month program Summer only

Full day: Mo Tu We Thu Fri Half day: Mo Tu We Thu Fri

Early Care (7:30-9:00am) Late Care (5:00-6:00pm) Early & Late Care (7:30am-6:00pm)

Pick Up
The child will be picked up by parents only_____
I give permission to the following people to pick up my child:
Name_____ Relationship_____ Phone _____
Name_____ Relationship_____ Phone _____
Name_____ Relationship_____ Phone _____

By my signature, I attest to the following:
* That the above information is correct.
* That in the event of a medical emergency, I authorize Jin-A Child Care Center to seek emergency medical care for my child as deemed necessary by the director or administrative assistant.
* That I have received and read the Parents Handbook.
* That my child is in good health and has no restrictions.

Parent/Legal Guardian Signature_____ Date _____

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Enrollment Agreement

Child's Name_____ Date of Birth_____

I hereby grant permission for my child_____ to participate in all of the activities of Jin-A Child Care Center and to use all the play equipment with no restrictions.

Financial Agreement
I agree to give one month's (four weeks) notice if I plan to withdraw my child. If I fail to give proper notice, I understand I am liable to pay one month (four weeks) after my child withdraws.

I have received the center's tuition schedule and agree to pay tuition on time. I also understand that, if my child stays beyond scheduled hours I will be charged additional fees.

I understand that if my payment is delayed for more than five working days I will be charged a late fee. After four weeks of delayed payment the child will not be able to attend Jin-A Child until all fees are paid.

I understand that any outstanding tuition bill after two months of termination will be collected by a collection agency at my cost.

By enrolling my child at Jin-A, I will become a member of the Jin-A Parents Association. I will attend the parent's meetings and information sessions. I also will be responsible to support the Parents Association by raising a minimum of **$100** (net/per school year) per child or make an equivalent cash donation.

Policies (See Parent's Handbook **Page 16 to 32**.)
I, the undersigned, have received and read the Parent's Handbook and agree to comply with the policies and regulations. In particular I have read: (*Please **check** each policy)

__Health and Safety Policy __Release / Waiver for Surveillance __Arrival and Pickup Policy
__Philosophy of Discipline __Assessment Policy __Termination Policy
__Information to Parents __Social Media Policy __Technology Policy
__I will notify the office in case I need more explanation or translation.

Information and Authorization
__I agree that my child's medical information may be shared among staff/teachers/emergency contacts and posted in designated areas of the classroom as necessary.

__I give permission for my child to be screened for development.

__I give permission to use my child's picture and work for school related documentation and publications (Jin-A website, documentations, yearbooks, news paper articles).

__I will inform Jin-A Child Care Center if there are any changes in the information of my registration packet and promptly update any phone numbers and medical information.

Also, in keeping with New Jersey's licensing requirements, we are obliged to provide you, the parent, with this informational statement.

> The statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Child Abuse Hotline at 1(877) NJABUSE.

Parent/Legal Guardian # 1_____ _____ _____
Print Name Signature Date

Parent/Legal Guardian # 2_____ _____ _____
Print Name Signature Date

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Medical Authorization Form

Medical Authorization For _____ _____
Child's Name Date of Birth

I, the undersigned parent or guardian, having legal custody of the above-named minor, hereby authorize Jin-A Child Care Center, into whose care said minor has been entrusted, to consent to any emergency medical treatment or hospital care to be rendered to said minor upon the advice of a physician or surgeon licensed under the provision of the Medical Practice Act or by a dentist licensed under the provisions of the Dental Practice Act.
I further authorize Jin-A Child Care Center to have said minor released into the custody of a Jin-A Child Care Center staff, should hospital care no longer be required.

This form is to be used **only in an EMERGENCY**, when I am unable to be contacted.

Medical Information: Please mention any information that may be helpful to hospital staff.

Allergies to medication or food_____
Ongoing Medication use by Child_____
Health problems (asthma, heart condition, seizures, diabetes, sickle cell. Etc.…)_____
_____
Other comments_____

Child's Health Care provider

Name _____ Phone_____
Address_____

Child's Health insurance

Name of Insurance Plan_____ Policy #_____
Subscriber's Name_____ Member ID # _____

List preference for transportation arrangement in an emergency situation (Parent/guardians are responsible for all transportation charges)
Hospital preference: 1st choice_____ 2nd choice_____

Emergency contact to whom child may be released if parent/guardian is unavailable:
Name & relationship _____
Home Phone_____ Work Phone_____ Cell Phone_____

As parent/guardian, I give consent to have my child receive first aid by the Jin-A Child Care staff.
I authorize Jin-A Child Care Staff to contact and share health information with both my child's **Health Care provider** and emergency contact if it is considered necessary.
I give consent for the emergency contact person listed above to act on my behalf until I am available.
I understand I will be responsible for all charges not covered by the insurance.

Parent/Legal Guardian # 1_____ _____ _____
Print Name Signature Date
Parent/Legal Guardian # 2_____ _____ _____
Print Name Signature Date

Home Phone_____ Mom (work) _____ (cell)_____

Other Phone_____ Dad (work)_____ (cell)_____

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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐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 give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐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)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

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

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EMERGENCY MEDICATION PLAN

JCCC is not able to give any medication (prescription and non-prescription) without written permission from parents and directions from a healthcare provider.

Name of Child _____ **Date of Birth**_____

*FEVER ACTION PLAN

Due to past seizures, other medical conditions, or distance of parent's work from childcare facility, Jin-A Child Care request a standing prescription for fever reducing medication. Medications should be brought to the office.

Temperature	Medication	How Much	How Often/When
100°F			
101°F			
102°F			
103°F			

Physician's Name_____ Phone#_____

Physician's Signature _____ Date_____

* valid one year

I give permission for my child to receive the above named medication(s) as prescribed.

Parent / Guardian's Name_____ phone#_____

Parent / Guardian's Signature _____ Date_____

* valid one year

OTHER

Jin-A Child Care requests parent's permission for the following over-the-counter medications. Medications should be brought to the office.

_____ I give permission for my child to have his/her own **sun lotion and sun protection** applied.

_____ I give permission for my child to have his/her own **diaper cream** applied.

Parent / Guardian's Name_____ phone#_____

Parent / Guardian's Signature _____ Date_____

* valid one year

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Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction ☐ Yes, I give permission to post this form at classroom.

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____

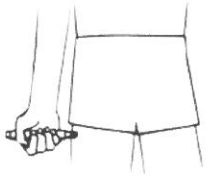
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**

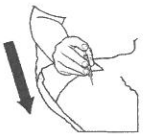
- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**

- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**



Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

June/2007

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Asthma Action Plan

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification

- ○ Mild Intermittent ○ Moderate Persistent
- ○ Mild Persistent ○ Severe Persistent

Triggers

- ○ Colds ○ Smoke ○ Weather
- ○ Exercise ○ Dust ○ Air pollution
- ○ Animals ○ Food
- ○ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ○ Take quick-relief medication every 4 hours for 1 to 2 days
- ○ Change your long-term control medicines by _____
- ○ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ○ Take quick-relief treatment again
- ○ Change your long-term control medicines by _____
- ○ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

- ○ Still in the red zone after 15 minutes
- ○ If you have not been able to reach your physician/health care provider for help
- ○ _____

Call an ambulance immediately if the following danger signs are present

- ○ Trouble walking/talking due to shortness of breath
- ○ Lips or fingernails are blue

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Medication Authorization Form

I hereby give permission for my child to receive the below listed medication, according to the given directions and cautions, from Jin-A Child Care Center Staff. I confirm that I have given at least one dose of medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container with the child's full name and measuring device needed for accurate administration. A maximum of two doses of medication will be given at school.

I authorize Jin-A Staff members to contact the Pharmacist or Health Care Provider for more information about this drug, if necessary.

Name of Child_____ Date_____

Name of Medication_____

Prescribing Health Professional's Name_____ Phone_____

Illness or condition_____

Dosage/Amount (tsp, ml, tablets) _____

Where to administer (circle): mouth ear eye skin other:_____

Time of day to be given (circle): 9am 10am 11am Noon 1pm 2pm 3pm 4pm 5pm

Dates to be given: Start Date: _____/_____/_____ End Date: _____/_____/_____
month day year month day year

Describe any side effects the medication may have: _____

_____

Suggestions to make the administration of medicine to my child easier: _____

_____

I understand that it is my responsibility to **pick up the medicine daily** from our office or classroom. (except emergency medications)

Parent's signature _____ Print _____ Date _____

I have received and understood the information provided. I will make sure that the right child receives the right medication, in the right dose, at the right time and by the right method as directed above.

Signature of staff_____Date_____