# *HEALTH CARE PROVIDER FORM*

**If you answered YES to QUESTIONS #20-29 ON THE REGISTRATION AND MEDICAL RELEASE FORM, you must** have a health care provider complete the AUTHORIZATION section below.
***Your child will not be enrolled into Snow Cubs without this form on file prior to their first date of attendance.***

Child's Name: _____ Date of Birth: _____
Child's height: _____ Child's weight: _____
Date of last health appraisal: _____ Next Well Visit scheduled for: _____
Health Insurance Company:_____ Policy #: _____

☐ I acknowledge that children 12 months and younger will be placed on their back to sleep.
☐ I give permission for this child to participate in all routine activities in child care. Any concerns or exceptions are identified on this form.

## HEALTH CARE PROVIDER AUTHORIZATION

**Child's Name: _____ Date of Birth: _____**
Please check the appropriate box below:
☐ Prescription
Must come in labeled container with the child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, pharmacy name and phone number. The licensed Health Care Provider's name must also be included.

☐ Over-the-Counter / Non-Prescription
Must be labeled with the child's name. Dosage must match the signed Health Care Provider Authorization form, and medicine must be packaged in the original container. In accordance with state law, we are only able to administer medicines with written instructions from the child's physician.

Self – Administration and/ or Self – Carry
Children may follow self-care procedures ONLY if the Health Care Provider Authorization and all necessary signatures have been provided. Children will not be permitted to take medication during care hours without the necessary paperwork on file.

☐ Food Allergy ☐ Special Diet ☐ Other:
If your child has an allergy that requires a prescription or is an over-the-counter medication, complete this Health Care Provider Authorization and all necessary signatures.

**Name of Medication: _____ Time(s) to be given: _____**
**Refrigeration: Y / N Start-End Dates: _____ Dosage:_____**
**Route: _____ Reason for Medication: _____**
**Last Episode: _____ Possible Side effects: _____**
**Medication Exp. Date: _____ Special Instructions: _____**
**How and where will the medication be stored: _____**
**Does the child need reminders, assistance in any way, or help? If so, please explain:**

_____ _____
*Signature of Health Care Provider, Address and Phone Number* *Date*

_____ _____
*Print Name of Health Care Provider* *Phone*

**The appropriate Care Plan must be attached for the following:**
☐ Asthma Care Plan ☐ Diabetes Care Plan ☐ Epi-Pen Care Plan
☐ Special Diet / Special Accommodation Form ☐ Medical Condition Accommodations
☐ Other:

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