2025-2026 Preschool Application Checklist

We are accepting **new** applications from November 5th to December 15th.
Accepted students will be notified on January 15th.

Dear Parents,

We appreciate your interest in our Preschool program. To ensure a smooth application process, kindly adhere to the following checklist. **Only completed applications will be accepted.**

Form #1 - Application Form

- Attach the **non-refundable** Admission Fee, payable to Hillsborough Recreation.

Form #2 - I.D. and Emergency Information

Form #3 - Consent for Medical Treatment

Form #4 - Student Accident Coverage

Form #5 - Health History – Parent Report

Form #6 - NEW STUDENTS ONLY/unless returning students with updates, Physician's Report – Must be filled out and signed or stamped by your child's physician. Return with the application. Required Vaccines to meet childcare immunization requirements:

- Three doses of **polio**
- Four doses of **DTP/DTaP**
- One dose of **MMR** (must be on or after first birthday)
- One Dose of **Hib** (only one OK but must be after first birthday)
- Three doses of **hepatitis B**
- One dose of **varicella**

Form #6A - Read and Review

Form #7 - Notification of Parents' Rights

Form #8 - Personal Rights

Form #9 - Behavior Standards

Form #10 -Photo Consent/HTV Permission

Form #11 - Parent Consent for Administration of Medications and Medication Chart

Copy of - Birth Certificate or Passport

- All new students must provide a copy of their Birth Certificate or Passport.
- An application is considered **incomplete** without a copy of a Birth Certificate or Passport.

All parents must have their fingerprints on file by **October 1, 2025,** to participate in classroom activities and field trips. A tuition deduction will be provided as reimbursement.

The Hillsborough Preschools
Tuition and Fee Schedule 2025-26

Program	**Admission Fee** All Students/Non-Refundable	***Two Pay Plan** June/Jan (Yearly)	***Nine Pay Plan** 9 months (Yearly)
RESIDENTS			
Preschool (3 day)	891	3,780 (7,560)	891 (8,014)
Preschool (5 day)	1428	6,064 (12,128)	1,428 (12,855)
Pre-K/TK (5 day)	1428	6,064 (12,128)	1,428 (12,855)
NON-RESIDENTS			
Preschool (3 day)	891	4,017 (8033)	946 (8,514)
Preschool (5 day)	1428	6,478 (12,955)	1,526 (13,732)
Pre-K (5 day)	1428	6,478 (12,955)	1,526 (13,732)

***Two Payment Plan:**
Due on: June 2, 2025 and January 1, 2026
***Nine Payment Plan: Due by the 1st of each month**
Due: June, Sept., Oct., Nov., Jan., Feb., March, April and May

Please write your child's name, school site and program on the bottom of your check
We accept credit card payments. Please be advised that a credit card processing fee will be applied.

Keep this form as your reference for payment due dates.
If payment has not been received by the 10th of the month in which it is due a $5 per calendar day late fee (per student) will be applied from the 1st of the month.

Admission Fee	The admission fee for each Preschool/Afternoon TK student is due with your application. This fee in **non-refundable and will be credited towards first tuition payment**
15% Sibling Discount	Applied to the lower program tuition
Withdraw Policy	A non-refundable withdrawal fee equivalent to one month's tuition will be assessed to prorated tuition based on payment plan.

NO TUITION ADJUSTMENT WILL BE MADE FOR VACATIONS, ILLNESS, OR IF A STUDENT IS ELIGIBLE FOR SERVICES THROUGH HILLSBOROUGH SCHOOL DISTRICT OR OTHER TIME OFF.

Tuition Statements will be emailed with payment directions - check and credit card payments are accepted *(fees will apply to credit card payments)*

The Hillsborough Preschools

Application for school year 2025 - 2026

First Choice_____ Second Choice_____ Third Choice_____

Check all that apply:

_____ New Resident Preschooler

_____ Sibling of Current Resident Preschooler

_____ Sibling of Resident TK-5 Student

_____ Sibling of Alumni

_____Registered HCSD TK Student

_____Hillsborough Public Employee/HCSD Employee

_____ Sibling of Current Non-resident Preschooler

_____ New Non-resident Preschooler

____ Returning Preschooler

Name of Child _____ Birth Date _____ Boy_____ Girl_____

Address _____ City_____ Zip_____

Telephone _____Email (#1) _____Email (#2) _____

Name of Parents Mother: _____ Cell #_____

(Or guardians): Father: _____ Cell #_____

Name I would like my child to be called at school: _____

All children must be fully toilet trained. Younger children may be accepted on a space available basis and at the Recreation Department's discretion.

To pick a class choose where your child's birthdate falls and then pick location (circle one):

Class*	Location	Birthdate	Days	Time
Preschool 3 day	North, South, West	12/2/22 – 2/1/23	M W F (limited spaces)	8:30 – 11:30
Preschool 5 day	North, South, West	9/2/21 – 12/1/22	M – F	8:30 – 11:30
PreK/*Transitional Kindergarten	TBD *Locations for HCSD TK to be determined	Already registered in HCSD TK program 9/2/20-9/1/21	M – F	12:30 – 3:30

Review the tuition payment plan attached. **Circle the payment plan selected**:

1. Two payment plan
2. Nine payment plan

Parent Signature: _____ Date: _____

We are excited to get the word out about Hillsborough Recreation and you are a valuable partner, we would like to purchase you a sweatshirt to wear as a parent.

Please select size Adult: Small Medium Large XLarge XXLarge

How did you hear about our program? _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

FORM #2

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE	ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
MOTHER S/GUARDIAN'S/MOTHER S DOMESTIC PARTNER S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

FORM #3

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

The Hillsborough Preschool (North, South, West) TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

FORM #4

STUDENT ACCIDENT COVERAGE

One alternative must be checked.

☐ My son/daughter is currently covered by Pacific Educators Student Insurance, 24 hour plan, purchased through the Hillsborough City School District.

☐ My son/daughter is currently covered by _____.
(Your current Health Insurance) Name of Insurance

I hereby absolve Hillsborough Recreation, its employees and officers from all liability that may arise as a result of my child's participation in the Hillsborough Preschool. I hereby give permission for his/her participation as indicated and in so doing absolve Hillsborough Recreation, its employees and officers from such liability.

SIGNED:_____ DATE:_____
Signature of Parent/Guardian

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

FORM #5

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHERS/MOTHER S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

FORM #6

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m., _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented)

☐ Communicable TB disease not present

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB.
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- Have, or are suspected to have, HIV infection.
- Live with an adult with HIV seropositivity.
- Live with an adult who has been incarcerated in the last five years.
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest X-ray suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

FORM #7

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: PENINSULA REGIONAL OFFICE - CHILD CARE

   Licensing Office Address: 801 TRAEGER AVENUE, SAN BRUNO, CA. 94066

   Licensing Office Telephone #: 650-266-8843

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

PERSONAL RIGHTS

FORM #8

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

PENINSULA REGIONAL OFFICE - CHILD CARE

ADDRESS

801 TRAEGER AVE, SUITE 100

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
SAN BRUNO	94066	650-266-8843

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

Dear Parents,

An important focus of the Hillsborough Preschool program is the continued development of the social skills and self-discipline necessary for the child to function successfully in small and large groups. At this point in the child's development, he/she should be acquiring a collection of strategies for handling problems and getting along with other children. Inappropriate reactive behaviors such as hitting, kicking, or biting should be discarded in favor of strategies such as talking out problems and requesting adult assistance.

Here at Hillsborough Preschool, no child may:
Hurt another in any way
Disrupt the work of another
Misuse the materials or equipment

We recognize that children mature at different rates and that they develop these positive social skills over time. However, to make the most productive use of the group's class time, the following process has been developed for use with those children who exhibit the inappropriate behaviors listed above:

1. **Removal from the group and/or activity for a limited period.**
2. **Counseling with the teacher and/or director. A conference will provide an opportunity for the exchange of ideas on how to help the child.**
3. **A probationary period of one to two weeks.**

In order to guarantee a quality experience for the total group, students who repeat these behaviors may be removed from the preschool program and their fees refunded.

Thank you,
Hillsborough Recreation

This will acknowledge that I/we, the parents of _____

Have read the above statement regarding behavior standards.

_____ _____
Parent/Guardian Signature Date

Hillsborough Preschool

Photo Consent

During the school year, we will be having many fun and exciting activities and experiences. We would like to document/share these activities by photographing and/or filming the students. Teachers and parents will be the photographers/videographers. We need your support and agreement to allow us to do this. The pictures/filming will be done during classroom activities, field trips etc. The pictures may be posted at school, used in a newsletter, slideshows, poster board displays, our school web community, school projects, our classroom photo website, publications/ads for the Hillsborough Preschools, class yearbook, and student memory albums/video and on our **Hillsborough Recreation web site and/or Hillsborough Recreation seasonal Catalog**. We will not include your child's last name *(with the exception of the yearbook)*, address, phone number or personal info when sharing/using the photos/film.

_☐_ Yes you may photograph/film my child for the purposes stated above.

_☐_ No you may not photograph/film my child.

Childs Name _____

Parent/Guardian Signature _____ Date _____

HTV Permission

Hillsborough Educational Television (HTV) is our local cable station shown on Cable Channel 27 only in the Town of Hillsborough. (HTV is not available on satellite). Parents, students, volunteers, and staff members will be filming student performances, presentations, and activities throughout the school year for viewing on HTV. HTV has strict guidelines to protect the privacy of our students. While your child's image may appear on HTV, programming does not include children's last names, addresses or telephone numbers. All programs pass through a multi-step review process before they are cablecast.

_☐_ Yes I give permission for my child to be filmed for HTV

_☐_ No I do not give permission for my child to be filmed for HTV

Childs Name _____

Parent/Guardian Signature _____ Date _____

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: Regulation Section 101221 requires the following information be on file.

CHILD CARE CENTER NAME:	LICENSE NUMBER: North 410709659 South 410518278 West 410518279	DATE:

PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME	DOSAGE

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From _____ (BEGINNING DATE) to _____ (ENDING DATE) at _____ (TIME OF DAY) daily while in attendance.

PARENT'S SIGNATURE:	DATE:

MEDICATION CHART
Staff Documentation of Medicine Administration

DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE
DATE	TIME GIVEN	STAFF SIGNATURE

Upon completion, return medicine to parent or destroy, and place form in child's record.

STAFF	DATE