Town of Blooming Grove

Orange County, New York

2026-2027
Blooming Grove Recreation
Latchkey Registration
Sunday, June 7, 2026
10am-12pm

PLEASE READ THE BELOW REGISTRATION INSTRUCTIONS....

Registration is mandatory for ALL, including families who are currently in the program. We will not be holding spots or accepting late registrations under any circumstances. We cannot accept any early registrations, before the registration date, or registrations via email (please do not ask for any special requests, as they will be denied). Registration is IN PERSON for ALL and is first come, first serve. First month's payment is due upon registration. We anticipate the program to fill up at registration. A waiting list will be formed after our maximum capacity is reached.

We are only accepting registrations for FULL TIME (4-5 days/wk) participants at this time.

Morning availability is VERY limited. A waiting list will be formed after the first 30 registrants.

REQUIRED health care forms (OCFS-6029, 7002, and 7006) for any child with an allergy (amoxicillin, peanuts, eggs, etc...), asthma, or any other special health care need (speech, hearing aids, etc.) are REQUIRED in order for your child to participate. Certain forms require a doctor's signature (see instructions for health care forms). Medication and prescriptions, BEFORE your child's first day, are also required in order for your child to participant. NO EXCEPTIONS! Without the proper required paperwork and medication, your child will be denied entry into the program. Medication must be in its original box with name and prescription. This policy is put in place to keep your child safe while in our care.

Once in person registration is complete, and the first payment is made via cash, check or money order, we will offer the option to enroll in online card payments. Payments will be automatically charged directly to your card at the beginning of the month via our website, www.bloominggrove.recdesk.com

Blooming Grove Recreation Latchkey Before & After School Program

- 1ST MONTH'S PAYMENT DUE AT REGISTRATION
- STARTS FIRST DAY OF SCHOOL
- ADDITIONAL CHILD DISCOUNTS!

Open to all children in Kindergarten through 5th grade in the Washingtonville School District and/or residents of the Town of Blooming Grove.

LIMITED SPACES AVAILABLE !!

REGISTRATION DATE:
Sunday June 7th
10am-12pm

First come, first serve.

TAFT ELEMENTARY SCHOOL
MONDAY-FRIDAY

TOWN OF BLOOMING GROVE RECREATION DEPARTMENT

49 Station Rd. Bldg. 1, Salisbury Mills, NY 12577
[LASSER PARK]

845-496-9201
BGRecreation@hotmail.com

TOWN OF BLOOMING GROVE RECREATION
REGISTRATION FORM – CHILDREN

Please Circle: BEFORE SCHOOL AFTER SCHOOL ____________ TODAY'S DATE__________

1. PARTICIPANT'S NAME_________________________AGE ________BIRTHDAY___/_____/______

2. PARTICIPANT'S NAME_________________________AGE ________BIRTHDAY___/_____/______

3. PARTICIPANT'S NAME_________________________AGE ________BIRTHDAY___/_____/______

LEGAL PARENT'S/GUARDIAN'S NAME____

ADDRESS____

HOME PHONE #_________________________________***CELL #**______________________________

***EMAIL ADDRESS:** ________________________________WORK #______________________________

Special Needs (7006 required) ____

Allergies/Asthma (7006/6029/7002 required)____

LOCAL EMERGENCY NAME AND PHONE # (NOT YOUR OWN) ______________________________

***GRADE/SCHOOL** ____________________________________

In consideration of the Town granting and continuing permission for use of its facilities, programs, and personnel: I hereby authorize my child, whose name appears above, to participate in the Town of Blooming Grove Recreation program; to travel to and from facilities and events conducted by the department. I hereby release the Town of Blooming Grove and its employees from any liability, claims, damage, or expense sustained by my child in connection with such participation.

In case of injury while at the program, I give permission for my child to be taken to a hospital for treatment – to include evaluation for injuries, X-ray, and any needed care. I understand the group leader will try to contact me in case injury occurs.

I have explained to my child that he/she is to obey the Town of Blooming Grove Staff and to follow rules and regulations set forth by them.

As with all Town of Blooming Grove Recreation Programs, credit is given only if a program is cancelled. Transfer of monies from one program to another is not permitted. There will be no credit or refunds if an instructor leaves during the session and is replaced within two weeks.

____

Legal Parent/Guardian Signature

FOR OFFICE USE ONLY:

Payment Amount: $_______________

Cash ________ Check #_____________ Money Order#_____________ Receipt# _______________

OCFS-6029________ **OCFS- 7006**________ **OCFS-7002**________ **OCFS-0792 (Day Care)** ________

LATCHKEY BEFORE & AFTER SCHOOL PROGRAM 2026- 2027

WHEN: The **After School Program** will begin the first day of school and run every Monday through Friday, 3:00pm-6:00pm. The **Before School Program** will begin the first day of school and run every Monday through Friday, beginning at 7:00am- dismissal.

WHERE: Taft Elementary School, Toleman Road, Washingtonville, NY

WHO: This program is open to all children, grades K-5, in the Washingtonville School District and/or residents of the Town of Blooming Grove. Transportation will be provided to Taft Elementary School from Little Britain & Round Hill by a school bus operating through the school district. **IF YOUR CHILD DOES NOT ATTEND TAFT ELEMENTARY, PARENTS MUST ARRANGE TRANSPORTATION FOR THEIR CHILDREN TO & FROM THE PROGRAM BY CALLING WASHINGTONVILLE TRANSPORTATION (845-497-4000 EXT 27101). STUDENTS MUST BE PICKED UP FROM TAFT AT/OR BEFORE 6PM.**

FEES:

AFTER SCHOOL:

4 OR 5 DAYS PER WEEK: 1st Child: $165 per month
Additional children: $115 each per month

2 OR 3 DAYS PER WEEK: 1ST Child: $115 per month
Additional children: $90 each per month

BEFORE SCHOOL:

4 OR 5 DAYS PER WEEK: 1st Child: $90 per month
Additional children: $70 each per month

2 OR 3 DAYS PER WEEK: 1st Child: $70 per month
Additional children: $50 each per month

*****PAYMENTS MUST BE RECEIVED BY THE FIRST SCHOOL DAY OF EACH MONTH. *****

Payments received after the first school day of the month will be charged an additional $15 late fee. Late and/or missed payments must be received by the 15th of month or your child will, unfortunately, be removed the Latchkey Programs.

ATTENDANCE: The Latchkey Programs are not equipped and will not follow up or make phone calls to determine the whereabouts of a child who is absent. **If you must reach the coordinator after 3:00pm, call Latchkey at 845-492-1827 or the Recreation office 845-496-9201.** In the event that you are running late for pick-up, you **must** make an alternate arrangement. As with the Town of Blooming Grove Recreation Programs, credit is given ONLY if we cancel a program. **"NO REFUNDS".**

____________________________ Parent/Guardian Signature

______________________ Date

Town of Blooming Grove Recreation

LATCHKEY BEFORE & AFTER SCHOOL PROGRAM 2026-2027

PLEASE READ THIS PACKET CAREFULLY AND SIGN ALL APPROPRIATE PLACES.

UPON REGISTRATION YOU WILL NEED THE FOLLOWING:

1. **COMPLETED REGISTRATION PACKET & OCFS-0792 (Day Care Form)**
2. **FIRST MONTH'S PAYMENT**
3. **HEALTH FORMS: OCFS 6029/7006/7002 (as required)**

There will be no registration fee. However, you must pay for the first month when you sign up. All payments are due by the first school day of each month. If your payment is not received by the first school day of the month, a $15 late charge will be added to your balance. Late payments are due by the 15th of the month. Payments must be handed in to the Latchkey Director/Site Supervisor or at the Blooming Grove Recreation office. **Cash, checks, & money orders will be accepted at Latchkey. Cash payments must placed in a sealed/labeled envelope. Please make checks/money orders payable to the "Town of Blooming Grove".**

If for any reason your child does not attend the Latchkey Programs, you still owe the full payment unless otherwise discussed with the Town of Blooming Grove Recreation Department Director. Automatic removal will occur after 1-month absenteeism.

If you are planning to remove your child from the Latchkey Program(s), you must submit a letter of removal in order to cease accrual of fees.

The Before and After School Programs are closed during holidays. The After School Program is closed anytime there is a cancellation of after school activities. Payment is expected in full for said days. The Blooming Grove Recreation reserves the right to cancel the Latchkey Programs in the event of inclement weather or in the event of an emergency.

AFTER SCHOOL ONLY: Please utilize the appropriate phone numbers in the event of an emergency or alternate pick-up. In the event you may be late, please make alternate arrangements to pick-up your child on time. Excessive lateness will be penalized with late fees. You will receive a warning after the first late pick-up and be charged a $30 late fee for any late pick-up from that point on.

Recreation Office: 845-496-9201
Transportation Department: 845-497-4000 (ext. 27101)
Latchkey: 845-492-1827

I have read and agree to the following rules and regulations listed above:

____________________________ __________________

Parent/Guardian Signature Date

Town of Blooming Grove Recreation

LATCHKEY BEFORE & AFTER SCHOOL PROGRAM 2026-2027

Authorized Pick-Up Form

Please provide below the names and phone numbers of three responsible adults, **other than yourself**, who live locally, and can pick up and care for your child until you return home in the event of early dismissal from the Latchkey Programs. These persons must be available during the program hours (7:00am-8:45am) and/or (3:00pm-6:00pm). Your child will not be released to anyone who is not listed on this sheet unless a handwritten note or email is provided stating otherwise.

Child Name(s):

____

Alternate Pick up 1:

Name: ______________________________ ____________________

Home Phone: ______________________________ Cell Phone: ____________________

Alternate Pick up 2:

Name: ______________________________ ____________________

Home Phone: ______________________________ Cell Phone: ____________________

Alternate Pick up 3:

Name: ______________________________ ____________________

Home Phone: ______________________________ Cell Phone: ____________________

Parent/Guardian Signature: ____

Date: ______________________________

Town of Blooming Grove Recreation

LATCHKEY BEFORE & AFTER SCHOOL PROGRAM 2026-2027

ALLERGY/ASTHMA ACTION FORM

If you have more than one child with asthma/allergies, please complete one form per child. It is not necessary to fill out this form if your child does not have asthma or allergies. ***Individual Allergy & Anaphylaxis Emergency Plans (attached form OCFS-6029 & OCFS-7006) are required for children with allergies/asthma. Medication (epi-pens/inhalers) must be provided on or before your child's first day in attendance. Medication Consent Form (OCFS-7002) is required, for EACH medication, for children with prescription medications (epi-pens/inhalers). Benadryl cannot be given unless it is in conjunction with an epi-pen. No topical ointments.***

Student Name: ___________________________________

Date of Birth: ____________________________________

Allergic To: _________________________________

Asthmatic (circle one): YES NO

SIGNS OF AN ALLERGIC REACTION

Systems:	Symptoms:
MOUTH	-itching, swelling of the lips, tongue, or mouth
THROAT	-itching and/or sense of tightness, hoarseness, and hacking cough
SKIN	-hives, itchy rash, and/or swelling about the face or extremities
STOMACH	-nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	-shortness of breath, repetitive coughing, and/or vomiting
HEART	- "thread" pulse, "passing out"

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE

ALL THE ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO LIFE THREATING SITUATIONS

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _______________________________________

   GIVE: __________________________________

   (Medication/dose/route)

2. Then call parent/guardian or emergency contact

   Name: __________________________________ Phone: ___________________________

   Name: __________________________________ Phone: ___________________________

_________________________________ _____________________

Parent/Guardian Signature Date

*Required

OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:	

CHILD'S FULL NAME:

SEX: ☐ Male ☐ Female

CHILD'S HOME ADDRESS:

DATE OF BIRTH:

HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE:

DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:

☐ Parent ☐ Guardian
☐ Caretaker ☐ Relative
☐ Other _____

HOME TELEPHONE NUMBER:

DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE

DATE:

For questions or additional information:

Phone: 845-496-9201

Email: BGRecreation@hotmail.com

INSTRUCTIONS FOR HEALTH CARE FORMS:

Any child with an allergy (regardless of what the allergy is), asthma, or any other special health care need (speech therapy, hearing aids, etc.), is required to have an Individual Allergy and Anaphylaxis Emergency Plan (OCFS-6029) and Individual Health Care Plan for a Child with Special Health Care Needs (OCFS-7006). Allergies include medications (amoxicillin, motrin, etc...), food (peanuts, eggs, shellfish, etc...), and environmental (grass, pollen, cats, etc...). Medication Consent Forms (OCFS-7002) are only required for children who have prescription epi-pens and inhalers. Benadryl can only be given if it is in conjunction with an epi-pen. Topical ointments are not permitted.

Individual Allergy and Anaphylaxis Emergency Plan (OCFS-6029): *Requires a signature from a doctor.* This form is utilized to develop written instructions outlining allergies, prevention strategies, and the required steps that must be taken if the child is exposed or showing symptoms of exposure to a known allergen. This form will be reviewed upon admission and annually thereafter.

Individual Health Care Plan for a Child with Special Health Care Needs (OCFS-7006): *Action plans from the doctor may replace this form.* This form is utilized to document an individual health care plan for a child with special health care needs. A child with a special health care needs means a child who has a chronic physical, developmental, behavioral, or emotion condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally (includes any child with an allergy or asthma). This form will be reviewed upon admission and annually thereafter.

Medication Consent Forms (OCFS-7002): *Required to be filled out and signed by a doctor.* This form is utilized for any child with a special health care need requiring prescription medications or oral over the counter medications. One form must be completed for each medication. This form will be reviewed upon admission and annually thereafter.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	Type of Exposure: (*i.e., air/skin contact/ingestion, etc.*):	Symptoms include but are not limited to: (*check all that apply*)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: X		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:

2. Date of Birth: / /

3. Child's Known Allergies:

4. Name of Medication *(including strength)*:

5. Amount/Dosage to be Given:

6. Route of Administration:

7A. Frequency to be administered: ______

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: ______

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe)*: ______

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* ______

11. Reason for medication *(unless confidential by law)*: ______

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /

15. Date to be Discontinued or Length of Time in Days to be Given: / /

16. Licensed Authorized Prescriber's Name (please print):

17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: ____________

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name)*:

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:
X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on / / (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / /

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X