SNOHOMISH COUNTY HEALTH DEPARTMENT

# *Diaper Cream/Ointment Authorization Form*

| Child Care Facility Name: |
|---|

Parent/Guardian permission is required for all diaper cream or diaper ointment application. The child care follows these guidelines regarding diaper cream and diaper ointment:

1. Acceptable diaper creams/ointments will be in compliance with WAC 110-300-0215: will be over the counter or prescription only and will list the active ingredients. Diaper creams and ointments are considered a medication. Homemade or herbal remedies are not accepted.
2. Diaper cream/ointment will only be applied to the area listed below.
3. Diaper cream/ointment will be provided by ☐ parents ☐ child care
4. If diaper cream/ointment is provided by parents, please label with child's first and last name.
5. Medications, including diaper ointment and sunscreen that are homemade, are not accepted.

***Please provide the following information:***

| | |
|---|---|
| Child's Name: | |
| Date of Birth: | |
| Name of Diaper Cream/Ointment: | |
| Reason for Diaper Cream/Ointment: | |
| Where to Apply: | How Frequently to Apply: |
| Active Ingredient(s): | |
| Medication Start Date: | Medication Stop Date: |
| Authorization Form Filled Out on: | Authorization Expires: (6 months from start.) |
| Comments or specific information (such as possible side effects, areas to avoid when applying diaper cream, etc): | |
| | |
| | |

**I authorize the use of the above diaper cream/ointment on my child. I understand that this cream will be applied to my child as indicated on this form.**

| | |
|---|---|
| Parent/Guardian Signature: | Date: |
| Daytime Phone Number: | |

*See back of form*



**Child Care Health Outreach Program**
3020 Rucker Avenue, Suite 202 ■ Everett, WA 98201-3900 ■ www.snohd.org ■ tel: 425.252.5415

# *Diaper Cream/Ointment Application Record*

Child's Name:

Name of Diaper Cream/Ointment to Be Used:

| *Date* | *Time* | *Initials* | *Date* | *Time* | *Initials* | *Date* | *Time* | *Initials* |
|---|---|---|---|---|---|---|---|---|
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***List any notes or side effects below. Notify parent/guardian immediately.***

***Signatures (and initials) of staff applying diaper cream:***

_____ (  ) _____ (  )

_____ (  ) _____ (  )

_____ (  ) _____ (  )



**Child Care Health Outreach Program**
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# Certificate of Immunization Status (CIS)

| Reviewed by: | Date: |
|---|---|
| Signed COE on File? □ Yes □ No | |

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

| **Child's Last Name:** | **First Name:** | **Middle Initial:** | **Birthdate (MM/DD/YYYY):** |
|---|---|---|---|
| | | | |

| I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record. | Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status. |
|---|---|
| X _____ **Parent/Guardian Signature** **Date** | X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date** |

| ▲Required for School ● Required Child Care/Preschool | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY |
|---|---|---|---|---|---|---|
| **Required Vaccines for School or Child Care Entry** | | | | | | |
| ●▲ DTaP (Diphtheria, Tetanus, Pertussis) | | | | | | |
| ▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+) | | | | | | |
| ●▲ DT or Td (Tetanus, Diphtheria) | | | | | | |
| ●▲ Hepatitis B | | | | | | |
| ● Hib (*Haemophilus influenzae type b*) | | | | | | |
| ●▲ IPV (Polio) (any combination of IPV/OPV) | | | | | | |
| ●▲ OPV (Polio) | | | | | | |
| ●▲ MMR (Measles, Mumps, Rubella) | | | | | | |
| ● PCV/PPSV (Pneumococcal) | | | | | | |
| ●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS | | | | | | |
| **Recommended Vaccines (Not Required for School or Child Care Entry)** | | | | | | |
| COVID-19 | | | | | | |
| Flu (Influenza) | | | | | | |
| Hepatitis A | | | | | | |
| HPV (Human Papillomavirus) | | | | | | |
| MCV/MPSV (Meningococcal Disease types A, C, W, Y) | | | | | | |
| MenB (Meningococcal Disease type B) | | | | | | |
| Rotavirus | | | | | | |

**Documentation of Disease Immunity (Health care provider use only)**

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
□ A verified history of varicella (chickenpox) disease.
□ Laboratory evidence of immunity (titer) to disease(s) marked below.

| | | |
|---|---|---|
| □ Diphtheria | □ Hepatitis A | □ Hepatitis B |
| □ Hib | □ Measles | □ Mumps |
| □ Rubella | □ Tetanus | □ Varicella |

□Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

## Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

**To print with the immunization information filled in:**
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

**To fill out the form by hand:**
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - □ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - □ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

**Acceptable Medical Records**
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

**Conditional Status**
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

**Reference guide for vaccine trade names in alphabetical order** For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

| Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine | Trade Name | Vaccine |
|---|---|---|---|---|---|---|---|---|---|
| ActHIB | Hib | Fluarix | Flu | Havrix | Hep A | Menveo | Meningococcal | Rotarix | Rotavirus (RV1) |
| Adacel | Tdap | Flucelvax | Flu | Hiberix | Hib | Pediarix | DTaP + Hep B + IPV | RotaTeq | Rotavirus (PV5) |
| Afluria | Flu | FluLaval | Flu | HibTITER | Hib | PedvaxHIB | Hib | Tenivac | Td |
| Bexsero | MenB | FluMist | Flu | Ipol | IPV | Pentacel | DTaP + Hib +IPV | Trumenba | MenB |
| Boostrix | Tdap | Fluvirin | Flu | Infanrix | DTaP | Pneumovax | PPSV | Twinrix | Hep A + Hep B |
| Cervarix | 2vHPV | Fluzone | Flu | Kinrix | DTaP + IPV | Prevnar | PCV | Vaqta | Hep A |
| Daptacel | DTaP | Gardasil | 4vHPV | Menactra | MCV or MCV4 | ProQuad | MMR + Varicella | Varivax | Varicella |
| Engerix-B | Hep B | Gardasil 9 | 9vHPV | Menomune | MPSV4 | Recombivax HB | Hep B | | |

# Child Care Registration Form

| Date child entered care | Date child left care |
|---|---|
| | |

| Child's name (Last, First, Middle) | Name used (Nickname) | Birthdate |
|---|---|---|
| | | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Child's parent/guardian name | Circle the best number to contact you at when your child is in our care | | |
|---|---|---|---|
| | cell phone # | home phone # | alternate phone # |
| | | | |

| Street address | City | Zip code |
|---|---|---|
| | | |

| Child's parent/guardian name | Circle the best number to contact you at when your child is in our care | | |
|---|---|---|---|
| | cell phone # | home phone # | alternate phone # |
| | | | |

*I give my permission for any of the following individuals to be contacted and my child may be released to any of them.*

*Parent/Guardian signature:* _____ *Date:* _____

**In an emergency, if you are not able to contact me, contact the following:**

| Name (first and last) | cell phone # | home phone # | alternative phone # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

These individuals also have permission to pick up my child:

| Name (first and last) | cell phone # | home phone # | alternative phone # |
|---|---|---|---|
| | | | |
| | | | |
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Child's health information

| Child's medical care provider or parent's/guardian's preferred medical facility for treatment<br>Name: Phone:<br>Street Address: | Child's last physical exam, if available |
|---|---|
| Child's dental care provider or parent's/guardian's preferred dental facility for treatment<br>Name: Phone:<br>Street Address: | Child's last dental exam, if available |

Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)

| Consent to medical care and treatment of minor children | | | |
|---|---|---|---|
| I give permission that my child, _____ may be given first aid/emergency treatment by the child care licensee and or qualified staff at:<br>Name of Licensee: _____<br>Address of Licensee: _____ | | | |
| Parent/guardian signature | Date | Parent/guardian signature | Date |
| When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.<br>I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.<br>I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct. | | | |
| Parent/guardian signature | Date | Parent/guardian signature | Date |

Washington State Department of CHILDREN, YOUTH & FAMILIES

# Child Care Parent/Guardian Permission

| Child's Name (First Middle Last) | Licensee's Name |
|---|---|
| | |

**Transportation and off-site activity**

I give my permission for the licensee or the licensee's staff to take my child:

| | Yes | No |
|---|---|---|
| To and/or from school: | | |
| By a personal vehicle | | |
| By riding with my child on public transportation | | |
| By walking with my child | | |
| On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken): | | |
| By a personal vehicle | | |
| By riding with my child on public transportation | | |
| By walking with my child | | |
| On occasional errands: | | |
| By a personal vehicle | | |
| By riding with my child on public transportation | | |
| By walking with my child | | |
| Other (specify here: _____): | | |
| By a personal vehicle | | |
| By riding with my child on public transportation | | |
| By walking with my child | | |

**Water activities including swimming pools and other bodies of water**

I give my permission for the licensee or the licensee's staff to:

| | Yes | No |
|---|---|---|
| Take my child swimming or play in a swimming pool or other body of water | | |

**Bathing**

I give my permission for the licensee or the licensee's staff to:

| | Yes | No |
|---|---|---|
| Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting | | |
| Give my child a bath or shower if my child is enrolled in overnight child care | | |

**Photo, video, or surveillance activity**

I give my permission for the licensee or the licensee's staff to:

| | Yes | No |
|---|---|---|
| Take photographs of my child ..... | | |
| Take video of my child ..... | | |
| Capture my child's image on surveillance video used at this child care facility ..... | | |

*I have reviewed the licensee's written policies and have had the opportunity to discuss with the licensee the policies pertaining to the items listed on this permission form.*

_____ _____

Parent or guardian signature Date

_____ _____

Parent or guardian signature Date

# CHILD CARE AGREEMENT

| First | Middle | Last |
|---|---|---|
| **Child's name:** | | |
| First | MIddle | Last |
| **Parent or Guardian name:** | | |

Days and times my child will receive care:

| Check days of care | ☐ Sunday | ☐ Monday | ☐ Tuesday | ☐ Wednesday | ☐ Thursday | ☐ Friday | ☐ Saturday |
|---|---|---|---|---|---|---|---|
| Arrival time | | | | | | | |
| Departure time | | | | | | | |

FEE: $_____ per:
- ☐ Hour
- ☐ Day
- ☐ Week
- ☐ Month

Date payment due:

Source of payment:
- ☐ Parent
- ☐ Other (specify):

Overtime rate: $ per:

Late fee: $ per:

**I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.**

**I have read, understand and agree to comply with the policy and procedures and information for parents given to me by:**

_____
Name of Licensee

| Parent or guardian signature | Date | Parent or guardian signature | Date |
|---|---|---|---|
| | | | |

**I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.**

Licensee signature Date

Street Address City State Zip code

Comments

# Child Care Medication Authorization Form

An early learning or school-age provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate cleaned and sanitized medication measuring devices.

| | | |
|---|---|---|
| Child's full name (first and last): | | Child's Birthdate: |
| Name of Medication (as it appears on medication container): | | |
| Dosage: | Start Date: | End Date: |
| To be given at the following times: | | |
| Reason for Giving Medication to Child/Medical Need: | | |
| Possible Side Effects of Medication: | | |
| Additional Information: | | |

**Prescription medication** must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name, the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

**Nonprescription (over-the-counter) medication** must be brought to the early learning or school-age program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

*I hereby give permission for the staff of _____ to give my child the medication as prescribed above.*
*(name of early learning or School age provider/program)*

_____ _____
*Parent/Guardian Signature* *Date*

**This section to be completed by child's parent or guardian, if applicable:**
*I, or my appointed designee, have provided training about specialized medication administration procedures for my child specific to this medication to the following staff member(s):_____*

_____ _____
*Parent/Guardian (or Designee) Signature Date* *Early Learning or School-ageProvider Signature Date*

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

| Child's Full Name | Today's Date |
|---|---|
| **CONTACT INFORMATION** | |
| Parent's/Guardian's Name | Telephone |
| Parent's/Guardian's Name | Telephone |
| Primary Health Care Provider | Telephone |
| Specialist (if applicable) | Telephone |
| Specialist (if applicable) | Telephone |
| **CHILD'S SPECIAL NEEDS** | |
| Diagnosis, if known: | |
| Known symptoms and triggers: | |
| Describe activity, behavioral, or environmental modifications that are needed for the child: | |
| Allergies (other than food allergy): | |
| For food allergies or special dietary needs due to a health condition - must obtain written instructions from child's health care provider (use page 3 of this form or health care provider's form) | |
| **MEDICATIONS** ***(Medication Authorization Form must be completed for each medication.)*** | |
| List medication to be given at **scheduled times**, and how medication is to be given. | |
| List medication to be given during an **emergency**, and how medication is to be given.<br><br>Describe symptoms that would trigger emergency medication. | |

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

**EMERGENCY RESPONSE PLAN**

List the steps and procedures the early learning provider should perform during an emergency related to your child's special need.

**SUGGESTED TRAINING FOR STAFF**

List suggested special skills training/education for the early learning program staff.

**SUPPORTING DOCUMENTATION**

Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 requires an early learning provider to have supporting documentation of the child's special needs provided by the child's licensed or certified:

(i) Physician or physician's assistant
(ii) Mental health professional
(iii) Educational professional
(iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or
(v) Registered nurse or advanced registered nurse practitioner.

**SIGNATURES**

| | |
|---|---|
| _____ | _____ |
| Parent or Guardian Signature | Date |
| _____ | _____ |
| Early Learning Provider Signature | Date |
| _____ | _____ |
| Health Care Provider Signature *(recommended)* | Date |

**This section to be completed by child's parent or guardian, if applicable:**

*I hereby give permission for* _____ *to provide*
(name of visiting health professional or specialist)

*services to my child at this early learning program.*

| | |
|---|---|
| _____ | _____ |
| Parent or Guardian Signature | Date |

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

## FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS

This page must be completed and signed by the child's health care provider and parent or guardian.

| Child's Full Name: | Today's Date: |
|---|---|
| Food the child must not consume (list each food separately) | Appropriate substitute food(s) |
| | |
| | |
| | |
| | |
| Describe allergic reactions and symptoms associated with this child's particular allergies. | |
| Describe the treatment plan for the early learning provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication). | |
| Other special dietary requirements due to a health condition. | |

_____ _____

Health Care Provider Signature Date

_____ _____

Parent or Guardian Signature Date

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

# *Sunscreen Authorization Form*

| |
|---|
| Child Care Facility Name: |

Parent/Guardian permission is required for all sunscreen application. Sunscreen products are applied to provide protection from the sun's UV rays. The child care follows these guidelines regarding sunscreen:

1. Acceptable sunscreens will be broad-spectrum with an SPF of 30 or higher.
2. Sunscreen will be applied 20-30 minutes before going outside, especially during the summer months and between 10 am and 4 pm.
3. Sunscreen will not be applied to children younger than 6 months without a doctor's note.
4. Parents are encouraged to send a hat with a wide brim for their child to wear outside.
5. Sunscreens will be stored at room temperature and out of reach of children.
6. Sunscreen product will be provided by: ☐ parents ☐ child care

***Please provide the following information:***

| | |
|---|---|
| Child's Name: | |
| Date of Birth: | |
| Name of Sunscreen and SPF: | |
| Active Ingredient(s): | |
| Authorization Form Filled Out on: | Authorization Expires: (6 months from start date) |
| Comments or specific information (such as possible side effects, areas to avoid when applying sunscreen, etc.) | |
| | |
| | |
| | |

**I authorize the use of the above sunscreen on my child. I understand that this sunscreen will be applied to exposed skin, which may include the face, ears, arms, shoulders, legs, and feet.**

| | |
|---|---|
| Parent/Guardian Signature: | Date: |
| Daytime Phone Number: | |

See back of form



**Child Care Health Outreach Program**
3020 Rucker Avenue, Suite 104 ■ Everett, WA 98201-3900 ■ fax: 425.339.5254 ■ tel: 425.252.5415

# *Sunscreen Application Record*

*See back of form for authorization.*

Child's Name:

Name of Sunscreen and SPF:

| *Date* | *Time* | *Initials* | *Date* | *Time* | *Initials* | *Date* | *Time* | *Initials* |
|---|---|---|---|---|---|---|---|---|
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***List any notes or side effects below. Notify parent/guardian immediately.***

***Signatures (and initials) of staff applying sunscreen:***

_____ (  )  _____ (  )

_____ (  )  _____ (  )

_____ (  )  _____ (  )



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