

RECESS RESOURCES, INC.

1/31/2008

**WRITTEN CONSENT FORM FOR APPLICATION OF
OVER-THE-COUNTER TOPICAL OINTMENTS PROVIDED BY THE PARENT
AUTHORIZATION PERIOD MAR – AUG**

| | | | |
|--|--|--|----------------|
| Child's Name: | | Date of Birth: | |
| Child's Known Allergies: [Allergies] | | Program: | |
| | | Age: | School: |
| TOPICAL OINTMENTS AUTHORIZED - (Please check boxes) | | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sunscreen - Strength: see product info, Dosage: To cover exposed skin area, | | | |
| Frequency to be administered & symptoms that necessitate administration: [] All outside Activities or [] Only for outside swim – To prevent sunburn from exposure to sun | | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Insect Repellent - Strength: see product info, Dosage: To cover exposed skin area, | | | |
| Frequency to be administered & symptoms that necessitate administration: All outside Activities – To prevent insect stings/bites | | | |
| NOTE: Route of Administration for all above topical ointments: Applied to surface of skin | | | |
| Possible Side Effects/Special Instructions: See product information | | | |
| What action should the child care provider take if side effects are noted: [] Contact Parent [] Other: _____ | | | |
| PARENT INFORMATION AND CONSENT | | | |
| I parent/legal guardian <input type="checkbox"/> AUTHORIZE <input type="checkbox"/> DO NOT AUTHORIZE the day care program to administer this topical item AS INDICATED IN THE SECTION ABOVE and understand that administration will be documented on my child's incident report provided to me for review and logged with date and time in my child's personal record maintained at the child care site. | | | |
| Parent/Legal Guardians Signature: | | Date: | |
| Parent Contact Info: | | Home: | |
| Employer: | | Cell: | |
| Parent Contact Info: | | Work: Ext: | |
| Employer: | | Home: | |
| Parent Contact Info: | | Cell: | |
| Employer: | | Work: Ext: | |
| CHILD CARE PROVIDER INFORMATION | | | |
| Facility Name: Recess Resources, Inc. | | Facility ID#: 000039224-SACC | |
| | | Facility Telephone #: 607-786-9006 | |
| My signature indicates that I have verified that all applicable information required for proper application of this topical product has been provided to and by the parents . | | | |
| Authorized Child Care Providers Name: Deborah Y. Fitzgerald, Exec. Director | | Date Received from Parent: | |
| Authorized Child Care Providers Signature: <i>Deborah Y. Fitzgerald, Exec. Director</i> | | | |
| CANCELLATION OF AUTHORIZATION | | | |
| I parent/legal guardian request that application of these topical items be discontinued on _____(date), I fully understand that once this authorization has been discontinued I will be required to complete a new authorization in order for it to be applied in the future. | | | |
| Parent/Guardian Signature: | | Date: | |