Permission To Release Information

I understand that the time my child _____ is in the facility, that the director may be asked for information regarding my child.

SELECT ONE AND SIGN BELOW:

☐ **I HEREBY GRANT** permission to release information to official persons only, who identify themselves, such as schools, health care personnel, welfare or other governmental officials.

☐ **I DO NOT GRANT** permission to release information about my child as set forth in the aforementioned statement. I understand that Child Care Licensing has access to my child's record as the licensing agent and may view the record upon Child Care Licensing facility inspection.

_____ _____

Signature of enrolling Parent/Guardian **Date**

Parent/Guardian Notification of NRS.178

I _____ (Parent/Guardian) am aware that I have the right to request and review any complaints the facility has received within the last 12 months of my child's(ren's) enrollment.

_____ _____

Signature of enrolling Parent/Guardian **Date**

CONSENT FOR MEDICAL TREATMENT

Parent/Guardian agrees the provider may consult with the child's nurse or attending physician in regards to child's health as needed. In the event that we should have questions regarding the health of the enrolling child we may contact one, or more, of the following sources for information.

- ✓ Hospital of choice and phone number _____
- ✓ Local Health Entity

DR. Name: _____ **Phone Number:** _____

Address: _____

In an emergency, I, _____, (parent/guardian), give my authorization to, _____, (provider's name) and any local physician, dentist or hospital to provide medical care and/or transport my child at my expense.

_____	_____	_____
Medical Plan	**Policy #**	**Phone Number**

Does your child require additional accommodations? Explain: _____

_____

Are the problems serious enough to restrict our child's activities?

Explain:_____

Describe, if any, special care required: _____

Does your child have frequent colds? ☐ **YES** ☐ **NO**

List any allergies staff should be aware of: _____

Is your child currently taking prescribed medication? ☐ **YES** ☐ **NO**

Name of medication?_____ Reason? _____

_____	_____
Signature of enrolling Parent/Guardian	**Date**

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CHILD'S HEALTH STATEMENT & SHOT RECORDS

We must have these before child can attend our facility.

Please have your child's doctor fill out this form or provide an office health statement, plus provide a copy of their shot records. These can also be emailed to office@tiptopchild.com

FOR MEDICAL OFFICE ONLY:

Child's Name: _____ Birth Date:_____

Parents Name: _____

Status of the above child's health: _____

_____

Any known conditions under treatment: _____

_____

_____

Child is capable of adjusting to programs of the child care facility:

☐ **YES** ☐ **NO** If no, reason: _____

_____

_____ _____

Signature of MD or RN **Date**

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CHILD PHOTO RELEASE FORM

We do not use child's name or tag parents in any posts.

SELECT ONE AND SIGN BELOW:

☐ **I HEREBY GRANT** to Tip Top Child Development Center the unqualified authorization to use and display on the social media, website and marketing promotional material, photographs taken of my child{ren). I certify that I am the parent and/or legal guardian of these child(ren). I will make no monetary or other claim of any kind against Tip Top Child Development Center or it's directors, adnrinistnltors or employees, for the use of the photographs of these child(ren).

☐ **I DO NOT** give my authorization to use my child(ren) pictures for any use other than at Tip Top Development Center for display

_____ _____

Signature of enrolling Parent/Guardian **Date**