

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I, _____ give **The Clifton School** staff permission to apply one or more of the following topical ointments/preparations to my child, _____ in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

Parent/Guardian

Signature Date

CHILD HISTORY INFORMATION

Child's Full Name _____

Name Most Often Called _____

Birth Date _____

FAMILY:

Parents: Married Divorced Remarried
 Separated Deceased

Age of child at time of any above changes in family situation _____

If divorced or separated, how often does child see the absent parent?

Siblings:	Names	Birth Dates
	_____	_____
	_____	_____
	_____	_____

Please list any other persons living with your family and indicate their relationship to the child.

If another person shares in caring for the child on a regular basis, please indicate name, relationship (if any), and days/hours this person is responsible for the child's care.

HEALTH:

Does your child have any dietary restrictions or allergies? Yes ____ No ____

If yes, please specify _____

Does your child have any physical or developmental special needs? Yes ____ No ____

If yes, please specify _____

Are any medications given regularly? Yes ____ No ____

If yes, please specify _____

Have there been any serious illnesses or hospitalizations? Yes ____ No ____

If yes, please describe circumstances: including age and length of time _____

DEVELOPMENTAL HISTORY:

If adopted, at what age? _____

At what age did your child first:

sit? _____ crawl? _____ walk? _____ talk? _____

Comments: _____

At what age was your child toilet trained? _____

Was training difficult? _____

At what age did your child first take a bottle? _____

At what age did your child give up the bottle? _____

Do you have any concerns about your child's development in any of the above areas? _____

SOCIAL:

For who was your child named? _____

What is the name of your child's best friend? _____

What is the name of your child's pet(s)? _____

How does your child relate to other children? _____

Does he/she seek friendships? _____

Does he/she enjoy playing alone? _____

How does your child relate to adults? _____

Does your child have any particular fears (dogs, sirens, thunder, etc.)? _____

Are there certain situations which anger your child? _____

How is your child limited or disciplined? _____

How do you reassure or reward your child? _____

Does your child have any particular habits or mannerisms, such as thumb sucking or nail biting?

Have you or your child had any extended separations from each other? How long? Who cared for him/her during that time? _____

How does your child react when you have to leave him/her? What do you find is best to say or do during those times? _____

ROUTINES:

Briefly describe your child's eating habits and food preferences. _____

Sleeping Patterns _____

What time does your child go to bed at night? _____

When does he/she go to sleep? _____

When does he/she get up in the morning? _____

How does he/she react when tired and/or needs a rest? _____

Does your child sleep with a favorite blanket or other items? _____

Does your child have any particular routines or special works about toileting? _____

Indicate what kinds of activities you believe your child would enjoy:

- | | | | |
|-------|-------------------------------|-------|------------------------------|
| _____ | Books, puzzles, blocks | _____ | Tinker toys, take-apart toys |
| _____ | Scissors, paste, glue | _____ | Balls, jump ropes, tricycles |
| _____ | Table games (Candyland, etc.) | _____ | Paper, pencils, crayons |
| _____ | Trucks, trains, cars | _____ | Dolls, dress-ups, dishes |
| _____ | Mud, water, sand, play-dough | | |
| _____ | Other, give examples _____ | | |

How long do you think your child will stay with an activity such as books or blocks?

Do you have concerns about any of your child's routines (sleeping, eating, etc.)?

CHILD CARE EXPERIENCE:

Has your child attended any other babysitter, daycare, or early learning center? If so, where and for how long? _____

Were there things he/she disliked about that experience? _____

PARENT'S PERSPECTIVE:

What do you hope your child will gain most from his/her experiences here? _____

How do you expect your child to adapt to this program? _____

Are there any additional circumstances regarding your child of which you would like us to be aware? _____

Culture, Traditions and Beliefs Form

Child's

Name _____ DOB _____

In the space below (use the back if additional space is needed) please share any information regarding your culture, traditions, beliefs and values and/or family traditions that you feel would be helpful with your child's transition to school.