



Orchard Valley Infant Health Care Plan
Parent/Guardian Permission

The parent/guardian of _____ ask that school/childcare staff provide the following
(Child's Name)
care to my child, according to the Health Care Provider's signed instructions on the bottom portion of this form.

Please note:

- The program agrees to administer medication prescribed by a licensed health care provider when program requirements are met and at the discretion of the program director
- It is the parent's responsibility to furnish the medication and equipment and to keep daily emergency contact information and authorization forms up to date
- All medications must be in the original container with labels matching Health Care Providers written directives

By signing this document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with program staff.

Parent/Guardian Name

Parent/Guardian Signature

Date

Home Phone No.

Work Phone No.

Health Care Provider Authorization

Child's Name: _____

Birthdate: _____

Please check the following:

- | | |
|---|--------------|
| <input type="checkbox"/> Swaddling | Notes: _____ |
| <input type="checkbox"/> Elevated Crib | Notes: _____ |
| <input type="checkbox"/> Alternate sleep position to back | Notes: _____ |
| <input type="checkbox"/> Swing/Bouncer Sleep | Notes: _____ |
| <input type="checkbox"/> Car Seat Sleep | Notes: _____ |
| <input type="checkbox"/> Food Thickener | Notes: _____ |

Comments:

Health Care Provider Signature

Date