Peters Family CAMP GLACIER HOLLOW STEVENS POINT AREA YMCA

2025 LIT 1 Camp Registration

Participant Name: ______________________________ **Birth Date** ______________

	LIT 1– AGES 12 TO 14	DATES	OPTIONAL OVERNIGHT ($10)	MEMBER COST	NON MEMBER COST
	NO LIT PROGRAMS				
	TRAINING (OVERNIGHT)	JUNE 8-13		TIER A $440 TIER B $400 TIER C $315	TIERED PRICING OFFERED FOR OVERNIGHT CAMPS
	PIRATES OF LAKE ELAINE	JUNE 16-20		$90	$120
	MYTHS AND LEGENDS	JUNE 23-27	JUNE 26 ☐	$90	$120
	STARS AND STRIPES	JUNE 30-JULY 2		$55	$70
	ECO ADVENTURE	JULY 7-11	JULY 10 ☐	$90	$120
	WACKY WATERS	JULY 14-18		$90	$120
	WILD, WILD WEST	JULY 21-25	JULY 24 ☐	$90	$120
	RAIDERS OF THE LOST ARTIFACT	JULY 28- AUG 1		$90	$120
	GLACIER HOLLOW OLYMPICS	AUG 4-8		$90	$120
	GAME SHOW MANIA	AUG 11-15	AUG 14 ☐	$90	$120
	SURVIVOR: CAMP EDITION	AUG 18-22	AUG 21 ☐	$90	$120
	LIT END OF YEAR TRIP (NEW TO 2025!)	AUG 24-29		$90	$120
	MESSTIVAL	AUG 25-29		$90	$120

	LIT 2– AGES 15 TO 17 (OR HAVE COMPLETED TWO SUMMERS OF LIT 1)	DATES	MEMBER COST	NON MEMBER COST
	NO LIT PROGRAMS			
	TRAINING (OVERNIGHT)	JUNE 8-13	TIER A $440 TIER B $400 TIER C $315	TIERD PRICING OFFERED FOR OVERNIGHT CAMPS
	ECO ADVENTURE	JUNE 15-20	$90	$120
	HOOFBEATS	JUNE 22-27	$90	$120
	BEGINNING EXPLORER 2	JUNE 29-JULY 2	$55	$70
	FISHIN'. HUNTIN', CAMPIN'	JULY 6-11	$90	$120
	ADVENTURE CAMP	JULY 13-18	$90	$120
	SPORTSAPALOOZA	JULY 20-25	$90	$120
	WILD WATERS	JULY 27-AUG 1	$90	$120
	WISE SPIRITS	AUG 3-8	$90	$120
	STRONG SPIRITS	AUG 10-15	$90	$120
	TWILIGHT TAMERS	AUG 17-22	$90	$120
	LIT END OF YEAR TRIP (NEW FOR 2025!)	AUG 24-29	$90	$120

TIERED PRICING FOR OVERNIGHT CAMP

OFFERING MORE OPPORTUNITIES TO MORE CAMPERS!

In our continuing efforts to offer the Camp Glacier Hollow experience to everyone, we understand that different families have differing abilities to pay. Our tiered pricing allows us to accommodate all financial situations. Please consider selecting the highest tier you can afford, allowing Camp Glacier Hollow to stretch our funding to continue improving the quality of our camp experience. Price B and Price C are subsidized by the YMCA through fundraising, special events, and contributions, requiring that you completing a subsidy survey that will be sent to the email address provided above.

- **Price C** is our historically subsidized rate, which does not represent the true cost of camp.
- **Price B** is a partially subsidized rate, but more clearly reflects the actual cost of camp.
- **Price A** most accurately reflects the actual cost of YMCA Camp Glacier Hollow.

OVERNIGHT CAMP REGISTRATION INFORMATION

1. Complete both sides and return this form along with a $100 non-refundable, non-transferable deposit or full payment for each session. If program is full, your deposit will be returned and you will be placed on a waiting list. Balance is due at least (4) four weeks prior to each camp session. An unpaid balance may result in forfeiture of your reserved spot. Invoices will not be mailed.
2. As your camp session gets closer, you will receive an email with specific details about your camp session.
3. Your child's completed health history profile and immunization information MUST be submitted with this registration form. The registration process will not begin until all completed forms are received. Parents are responsible for any changes to the profile including emergency contact and authorized pick up information.
4. We will return all fees except your deposit if written cancellation is made four weeks prior to session. After four weeks, refunds may not be available.
5. All Stevens Point Area YMCA Family and Single Parent Family members are eligible for a $25 Member Discount for "LIT Training."

DAY CAMP REGISTRATION INFORMATION

1. Fully complete both sides of the Day Camp Registration and submit, with $30 (per week) deposit. If the requested program is full, your deposit will be returned and you will be placed on a waiting list. Deposits will not be returned due to changes or cancellations initiated by camper families. **Incomplete registrations will not be processed.**
2. A one-time, non-refundable $25 Camp Registration fee is also required. This fee only needs to be paid once, regardless of the number of weeks your camper is registered.
3. Your child's completed health history profile and immunization information MUST be submitted with this registration form. The registration process will not begin until all completed forms are received. Parents are responsible for any changes to the profile including emergency contact and authorized pick up information.
4. Balance is due at least (2) two weeks prior to each camp week. An unpaid balance may result in forfeiture of your child's registration. All balances will be auto drafted from the debit/credit card provided for weekly balances. Invoices will not be mailed. You will be charged a $20 service fee to transfer between weeks or programs.
5. Approximately one week prior to each camp, you will receive an email with general camp information, arrival and departure times, and a list of things to bring.
6. We will return all fees except your Registration Fee and Deposit if written cancellation is made two weeks prior to each session. After two weeks, refunds

DAY CAMP

❒ Participant is SPYMCA Family or Single Parent Family Member

❒ $25 Summer Camp Registration Fee

❒ $30 Deposit (per week) or payment

TOTAL DUE: $______________

OVERNIGHT

Tier Price: A B or C $____________

Y Member Discount (-$25): $_______

$100 Dep. Required. Total Paid Now: $ _______________

❒ Check Enclosed ❒ Charge My Card:

Amount: $ _________________

❒ Visa ❒ Master Card ❒ Discover ❒ American Express

Card #: ____ Exp Date:__________

Name on Card: ____

The YMCA guarantees satisfaction with the quality of its services. This authorization will remain in effect until revoked by me in writing and until you actually receive such notice, I agree that you shall be fully protected in honoring any such charge. I agree that your treatment of each such charge and your rights in respect to it, shall be the same as if it were signed by me and that if any such charge be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of services.

If at anytime the amount in my account is insufficient to cover the amount to be deducted, the bank is not obligated to pay and is not responsible for these insufficient funds. Nor shall the bank be liable for any errors by the Stevens Point Area YMCA in handling the terms of this authorization.

I will use an electronic funds transfer to pay for services and I agree that if for any reason I wish to terminate or change the status of services, I must give the **YMCA WRITTEN NOTICE 15 DAYS IN ADVANCE** of my automatic withdrawal date. A $20.00 service fee will be charged on any returned bank draft. _______________________

Initial Here

YMCA CAMP GLACIER HOLLOW
2025 CAMP Registration

Participant Name ______________________________ Birth Date ____________ Age at Camp _____

Gender _______ Grade Next Year ______________________________

Are there any medical, custodial, physical, behavioral conditions or special needs that we should be aware of now?

____

____

Have you attended an overnight camp before? __________ I am a returning camper. This is my __________ year at camp.

Parent 1 Contact Information:	Parent Contact Information:
Name: ______________________	Name: ______________________
Phone Number: ______________________	Phone Number: ______________________
Email: ______________________	Email: ______________________

Emergency Contact:	How did you hear about YMCA Camp Glacier Hollow?
Name: ______________________	☐ YMCA Center
Phone Number: ______________________	☐ Internet
Email: ______________________	☐ Social Media
	Other: ______________________

I understand that all reasonable safety precautions are taken by the YMCA in the operation of its facility, equipment and programs. I am aware of and accept all the risks inherent in the program. I agree that my or my child's voluntary participation in Day Camo, Resident Camp, Teen Leadership Programs, and/or Outdoor Adventure Trips shall be undertaken at my or his/her sole risk, and that the YMCA and Camp Glacier Hollow, its directors, employees, volunteers and agents shall not be liable for any claims, injuries, damages, losses, diseases, wrongful death, actions or cause of action whatsoever, to me, my child and his/her property, arising out of or connected to participation in Resident Camp, Teen Leadership Programs, and/or Outdoor Adventure Trips including but not limited to transportation services, camping, canoeing/kayaking, rafting, hiking, swimming, biking, rock climbing, fishing, horseback riding/grooming, and other camp activities. In the event that I cannot be reached in an emergency, I authorize the YMCA staff to transport to or secure emergency services for me or my child, and I give my consent for the YMCA staff to act on my behalf in granting permission for me or my child to receive any emergency treatment deemed necessary including, hospitalization, injection, anesthesia or surgery. I agree that I will be responsible for the payment of any and all medical services rendered. I give permission for my child or I to appear in media coverage approved by the YMCA and for the YMCA to use photographs and videos of my child or I for promotional purposes and social media. I give permission to the Camp Health Staff to give my child or I over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, body aches, insect bites, sun protection, etc...) I give permission for my child or I to use sunscreen (Rocky Mountain Sunscreen SPF 50 Lotion for Kids) and insect repellent and receive assistance as needed from Counselors, unless otherwise noted on my child's or my Health History form. I hereby apply for a reservation for my child as a program participant. I agree to pay the total camp fee on or before the payment due date. I understand that failure to pay by the due date may forfeit my application and deposit. Furthermore, if my child or I are forced to leave the program due to illness, injury, or inappropriate behavior, a refund may not be available. I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's or my registration and/or participation in this program.

I have carefully read, initialed and fully understand the above warning of risk and parent/guardian consent and waiver & release sections. I fully understand that by signing this form I have given my parent/guardian consent on all sections contained within.

____ ________________

Parent/Guardian Signature **Date**

Completed paperwork and payment can be mailed or dropped off at
The Stevens Point Area YMCA - Camp Registration, 1000 Division Street, Stevens Point, WI 54481
(715)342-2999

YMCA CAMP GLACIER HOLLOW
2025 Refer A Friend & Trading Post Form

Participant Name: ____ **Camp Attending:** __Day Camp __Overnight Camp ___LIT/CIT

RECRUIT A FRIEND TRADING POST CREDIT

Recruit a friend (non-sibling) who has not attended one of our Camps before and you will receive a $25 Trading Post Credit. The friend that you refer will also receive a $25 Trading Post credit. There is no maximum credit amount, so recruit more than one friend and get additional credits! Credits are not redeemable for cash.

❐ **I recruited:** ____

❐ **I was recruited by:** ____

New for 2025:

Cash will **not** be accepted for adding funds this year. Funds can be added using this form, online, or over the phone by calling the Stevens Point YMCA at **(715) 342-2980**. **Do NOT send cash with Campers.**

Authorization for Trading Post Account Funds

I hereby authorize The Stevens Point Area YMCA to charge the credit/debit card provided on the previous page to fund the Trading Post account for the camper listed below. I understand and agree that:

1. This authorization allows The Stevens Point Area YMCA to charge the card for an initial deposit to the camper's Trading Post account.
2. The camper(s) will use the Trading Post account for purchases during their stay, and funds will be deducted from the account as items are purchased.
3. The card will only be charged for the initial deposit and any additional approved funds.
4. The SPYMCA will not automatically process additional payments without your authorization. (See Below)

Authorization Statement: By signing below, I acknowledge and give permission to The Stevens Point Area YMCA to process charges using the card information provided earlier for the purposes of funding the Trading Post account. A $20 service fee will be charged on any returned bank draft. I understand that all transactions will be processed securely and any unspent funds (Except for Recruit-A-Friend Credits) may be refunded at the end of the camp session, according to camp policy.

Cardholder Signature: ____ **Date:** ____________________

Name(s) of Camper(s)____ **Amount: $** ___________

***Card #:** ____ **Exp. Date:** _______________

Name on Card: ____ **Total Amount Paid Today: $** _________

Completed paperwork and payment can be mailed or dropped off at
The Stevens Point Area YMCA – Camp Registration, 1000 Division Street, Stevens Point, WI 54481
(715)342-2999

Stevens Point Area YMCA

School Age/Day Camp – Health History and Care Form

FULLY COMPLETE ALL SECTIONS of this REQUIRED Health and Care Form and return to:
Stevens Point Area YMCA, Child Development Office, 1000 Division Street, Stevens Point, WI 54481 (715) 342-2999

First Day of Attendance: ________________

Participant Name ____ Birth Date _________ Age _____ ❑ M ❑ F

Street Address ____
Street City State Zip

Home Phone __________________ School ___________________ Grade______ Height _____ Weight_____

Parent/Guardian Name ___________________________

Home Address ___________________________________

City _________________ State _______ Zip _______

Place of Employment and Phone # _________________

____

Cell Ph.________________ Home Ph. _______________

Cell Service Provider (for ER txt) __________________

Email Where Reachable While Child is in Care:

____

Parent/Guardian Name______________________________

Home Address _____________________________________

City ____________________ State _______ Zip ______

Place of Employment and Phone # ____________________

____

Cell Ph.________________ Home Ph. _________________

Cell Service Provider (for ER txt) _____________________

Email Where Reachable While Child is in Care:

____

Please Indicate any Custody Issues ____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up Child.

Emergency Contact Name ________________________

Relationship to Child _____________________________

Place of Employment and Phone # _________________

____

Cell Ph.________________ Home Ph. _______________

Cell Service Provider (for ER txt) __________________

Email Where Reachable While Child is in Care:

____

Emergency Contact Name___________________________

Relationship to Child ______________________________

Place of Employment and Phone # ____________________

____

Cell Ph.________________ Home Ph. _________________

Cell Service Provider (for ER txt) _____________________

Email Where Reachable While Child is in Care:

____

Participant Physician ____ Phone _______________
Dr. Name/Facility Office Address

Participant Dentist ____ Phone _______________
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ____ YES ___ NO

Carrier or Plan Name _____________________________ Member ID # _______________ Group # _____________

Carrier Address & Phone # ____

Name of Insured ______________________________ Relationship to Participant ___________________________

Emergency Treatment Authorization: In the event I cannot be reached in an emergency, I authorize the YMCA staff to transport to and/or secure from any licensed hospital, physician and/or medical personnel any emergency care or treatment deemed necessary for my child. I agree that I will be responsible for the payment of any and all medical services rendered.

Signature of Parent/Guardian ____ **Date** ____________________

OVER

Participant Name ______________________ Birth Date __________ Age ______ ❑ M ❑ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

❑ Sleepwalking	❑ Frequent Ear Infections	❑ Skin Problems	❑ Cerebral Palsy/Motor
❑ Bed-wetting	❑ Heart Defect/Disease	❑ Joint/Bone Problems	❑ Picky Eater
❑ Athlete's Foot	❑ High Blood Pressure	❑ Head/Neck/Back Injuries	❑ Vegetarian
❑ Warts	❑ Diabetes	❑ Epilepsy/Convulsions/Seizures	❑ Allergies
❑ Eating Disorder	❑ Frequent Headaches	❑ Visual Impairment/Glasses…	❑ Asthma
❑ Diarrhea/Constipation	❑ Indigestion	❑ Hearing Impairment/Aids…	❑ Other __________
❑ Abnormal Menstruation	❑ Sinus Trouble	❑ Speech Impairment	❑ Other __________
❑ Homesickness	❑ Frequent Nose Bleeds	❑ Learning Disability	
❑ Doesn't Swim (describe)	❑ Bleeding Clotting Disorder	❑ ADD or ADHD	❑ Does participant have a School IEP? If yes please provide a copy.
❑ Nightmares	❑ Fainting/Dizziness	❑ Cognitive Disability	
❑ Exercise Induced Difficulties	❑ Emotional/Behavior Disorder	❑ Chronic Illness/Condition	

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: ____

____

____

Identify any YMCA staff that you have given specialized instructions/training to: ____________________

ALLERGIES Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications (list)

______________ ____

______________ ____

Foods (list)

______________ ____

______________ ____

Insects, Animals, Plants…

______________ ____

______________ ____

MEDICATIONS

Will participant medication need to be taken during this program? ____ Yes ____ No ____ Maybe *If yes or maybe, a* Authorization to Administer Medication form must be completed (Attached to this packet). All Medications are required to be in original containers and be clearly labeled.

List and describe any other participant Health Conditions/Disorders/Impairments/Diseases/Illnesses/Major Surgeries/ Special Needs and indicate if there are any Restrictions: ______________________________

____

____

*** A copy of participant's immunization records or provided form must be attached.**

I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's participation in this program.

________________________ ________________________ __________

Participant Name - Please Print Signature of Parent/Guardian Date

Review dates: __________ __________ __________ __________ __________

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (02/2023)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1

PERSONAL DATA

PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2

IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (Chickenpox)					

History of Varicella/Chickenpox

In accordance with DHS 144.03(2)(g), I attest that this child has a reliable history of varicella disease and is not required to receive Varicella vaccine.

SIGNATURE – Physician/PA/APNP Date Signed

STEP 3

REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only two doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose four days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only two doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4

COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations __________(List in STEP 2 any immunizations already received)

Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5

SIGNATURE

To the best of my knowledge, this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

Authorization to Administer Medication – Child Care Centers
Instructions For Use

Use of form: This form is mandatory for licensed family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps, and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a., and DCF 202.08(4)(f)2.b. Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting that the provider administer prescription or non-prescription medication to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place the form in the child's file when the medication is no longer required / authorized. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

CERTIFIED CHILD CARE OPERATORS

This form is voluntary for certified providers; however, completion of Page 1 *Medication Information and Authorization* and Page 2 *Documentation of Medication Administration – Certified Child Care Providers* meets the requirements of DCF 202.08(4)(f)2.b., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*. Record administration of the authorized medication in the spaces provided on Page *2 Documentation of Medication Administration – Certified Child Care Providers*. Lines should not be skipped.

LICENSED FAMILY CHILD CARE CENTERS:

Page 1 *Medication Information and Authorization* is mandatory for licensed family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Family Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Center Medication and Injury Log – Directions for Use* available from the Child Care Information Center website as part of the Appendix J Resource List.

LICENSED GROUP CHILD CARE AND DAY CAMPS:

Page 1 *Medication Information and Authorization* is voluntary for group child care centers and day camps; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a. and DCF 252.44(6)(e)1.a., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Group Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Center Medication and Injury Log – Directions for Use* available from the Child Care Information Center website as part of the Appendix J Resource List.

Authorization to Administer Medication – Child Care Centers
Medication Information and Authorization

A. FACILITY AND CHILD INFORMATION

Child Care Center Name

Child Name

Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes," I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

OTC Medication Name

Parent Initials

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian

Date Signed

Authorization to Administer Medication – Child Care Centers
Documentation of Medication Administration – Certified Child Care Providers

Instructions: This section is to be completed only by **certified child care providers** to document the actual administration of the medication. Lines should not be skipped.

	Name of Medication	Date Administered	Time Administered	Dosage	Signature / Initials of Person Who Administered the Medication
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					