# WILD ABOUT CAMP

## Riverfront YMCA Summer Day Camp Enrollment Packet

## June 2, 2025–August 15, 2025

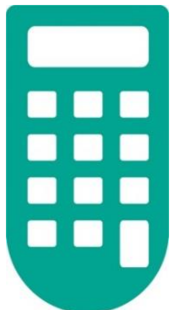
Serving children who have completed Kindergarten through age 12

Riverfront YMCA
544 Broad Blvd.
Cuyahoga Falls, OH 44221
(330) 923-9622

Mission: To put Christian principles into practice through programs that build a healthy spirit, mind, and body for all.

# PARENT INFORMATION PAGE

Tear off and keep for your records!



### CAMP FEES

**Registration Fee:** $40.00 per child
*Waived until April 15
**YMCA Member:** $190/ Week
**Program Member:** $210/week

Auto draft is REQUIRED. Account information must be provided at the front desk upon registration.

### CAMP TIMES

**Before Care:** 7:00-9:00 am
**Camp:** 9:00 am-4:00 pm
**After Care:** 4:00-6:00 pm

Before and After Care are provided at no extra charge for children attending day camp. The child needs to arrive at camp by 8:45 am each day.

### WHAT TO BRING

- Camp t-shirt
- Closed toe shoes (tennis shoes)
- Packed lunch
- Water bottle
- Backpack
- Swimsuit and towel

****LABEL ALL ITEMS****

### WHAT NOT TO BRING

-Open toe shoes (flip flops)
-Crocs
-Cell phones and other electronics
-Toys from home
-Valuables
-Two Piece Bathing Suits

### DATES TO REMEMBER

**First Day of Camp:** June 2nd
**Last Day of Camp:** August 15th
**No Camp:** July 4th

**Open house on** May 29, 2024 from 6:30 pm- 8:30 pm

### PASSPORT PROGRAM

Register your child for 6 or more weeks of Day Camp and receive 20% off a week of Adventure Camp (Overnight) at Camp Y-Noah! To take advantage call Camp Y-Noah at 877-GOT-CAMP!

From exercise to education, from volleyball to volunteering, from preschool to preventive health, the Y doesn't just strengthen bodies- we strengthen community! The YMCA strives to make programs and memberships available to all. Financial Assistance is available to those who qualify.

**WHO TO CALL:** 330-923-9622

**Dalton Bergert**
Assistant Child Care Director
daltonb@akronymca.org

**Grace Cominsky**
Youth Enrichment Director
gracec@akronymca.org

**Laura Davisson:**
Youth Enrichment Director
laurad@akronymca.org

## Summer Day Camp 2025

Please select the weeks and/or service you need:

☐ Week 1: June 2-June 6
☐ Week 2: June 9-June 13
☐ Week 3: June 16-June 20
☐ Week 4: June 23-June 27
☐ Week 5: June 30-July 4 (no camp 7/4)
☐ Week 6: July 7-July 11
☐ Week 7: July 14-July 18
☐ Week 8: July 21-July 25
☐ Week 9: July 28-August 1
☐ Week 10: August 4-August 8
☐ Week 11: August 11-August 15

Payment Information:

Weekly Payment Amount: ☐ $190 (YMCA Members) ☐ $210 (Non-Y Members) ☐ Other (contact director)
Please draft payment: ☐ Weekly on Fridays ☐ Other (contact director)
Account: ☐ Use account on file (ending in _____) ☐ Provide account info at registration ☐ FLEX (contact director)
Person responsible for tuition: ________________________________
Do you have Title XX? ☐ Yes ☐ No
Are you or another parent/guardian currently an employee of the YMCA? ☐ Yes ☐ No
If yes, what is his/her name? ____________________________________________________________

Child and Family Information:

Child's Name and Nick Name __________________________________________ ☐ male ☐ female
Child's Birth date ____________________ Age _______
Street Address _____________________________________________________
City ______________________________ State __________ Zip ___________
School child is attending in Fall 2025 ____________________
Grade child is entering in Fall 2025 _________
Shirt Size (please circle) YS YM YL AS AM AL AXL

Parent Name _______________________________
Primary Number ( ) ☐ C ☐ H ☐ W
Secondary Number ( ) ☐ C ☐ H ☐ W
Email _____________________________________
Birth date _________________________________

Parent Name _______________________________
Primary Number ( ) ☐ C ☐ H ☐ W
Secondary Number ( ) ☐ C ☐ H ☐ W
Email _____________________________________
Birth date _________________________________

### Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require a government issued identification before releasing your child.

Name ___________________________________________ Relation ________________________________
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ___________________________________________ Relation ________________________________
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ___________________________________________ Relation ________________________________
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ___________________________________________ Relation ________________________________
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Please note: if there are any custody issues involved with your child, you must provide the center directors with full court papers including who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation.

****If you receive publicly funded child care, all authorized persons to pick up will be required to use the mobile TAP system****

Child's name ______________________________

# 2025 Center Policies Agreement

Please read the policies carefully and **INITIAL** all lines.

________ I understand there is a $40 non-refundable registration fee per child.

________ Weekly tuition is due on Fridays prior to the week of service via auto draft.

________ I understand that if my childcare payments fall one week behind I will be asked to withdraw my child until payment is made.

________ Outstanding balances of $100 or more that are past 30 days in arrears will be turned over to collections.

________ I understand that if I have any outstanding balance at any facility within the Akron Area YMCA Association I am unable to register for any programs or membership until balance is paid.

________ I understand that there will be a $10 fee assessed for any and every returned payment.

________ CANCELLATION POLICY: Notification must be given no later than one week in advance. Otherwise, I understand that I will be responsible to pay that week's tuition in-full, regardless of attendance.

________ I understand that late pick-up fees in the amount of $15 for every 15 minute increment per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:00 pm).

________ I understand that staff will contact Summit/Medina County Children Services if my child remains at the center longer than one hour after closing and all attempts to reach me, the child's other parent, and authorized persons have been made, without success.

________ I understand that state licensing requires that all forms in this registration packet must be completely filled out and turned in prior to the child's admission to the program.

________ I understand that I am required to disclose all medical, physical, or behavioral issues that pertain to my child at the time of enrollment, and supplement that information on an ongoing basis as needed.

________ I have read the YMCA BASE/Day Camp Registration Packet and agree to all terms therein for my child(ren) to receive childcare. I understand that I forfeit the privilege of childcare if all policies are not followed.

FOR PUBLICLY FUNDED CHILD CARE RECIPIENTS ONLY

________ I understand that my Publicly Funded Child Care co-pay is due every Friday via auto draft prior to care.

________ I understand that if my Publicly Funded Child Care authorization is not current and/or not for the correct location, I will be responsible for private pay rates.

________ I understand that I must tap using a mobile device daily. I understand there is a back date period if daily taps are missed. If I miss the back date period, I understand that I will be charged the difference between my co-pay and the weekly private-pay rates. I understand it is my responsibility to know for which dates and times I need to back date.

Parent/Guardian Signature ________________________________________ Date __________________________

Child's name ________________________________

## Program Waiver

I/We understand that there is a risk of serious injury associated with the use of the YMCA facilities, participation in YMCA programs and use of exercise and other equipment. As a condition of my membership I agree to assume the risk of injury arising from my use of the facilities, programs, equipment and for all other matters at all YMCA locations or programs whenever occurring. On behalf of myself and my heirs, administrators and agents and contractors harmless from all such claims for injury and damage. I understand that I would not be permitted to participate in any YMCA program or use any YMCA facility or equipment without signing this agreement. I authorize the Akron Area YMCA or its designees, agencies and contractors to create, have and use photographs, slides and videotapes containing my image for its recordkeeping or marketing/public relations programs.

Parent/Guardian Signature ________________________________________ Date ___________________

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## Photograph Consent

I give my permission for my child __________________________________ to be photographed for the promotion of the Akron Area YMCA.

Parent/Guardian Signature ________________________________________ Date ___________________

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## Permission for Routine Walks

Weather permitting, I give permission for my child __________________________________ to accompany his/her group on routine walks in the neighborhood of the YMCA.

Parent/Guardian Signature ________________________________________ Date ___________________

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## Permission for Routine Field Trips

I give permission for my child ____________________________________ to accompany his/her group on routine field trips throughout the week from 9:00am-4:00pm June 2, 2025- August 15, 2025. Transportation is provided by school busses (CF City Schools Transportation Services). Specific dates and trip locations will be available by May 21, 2025 at the latest.

Parent/Guardian Signature ________________________________________ Date ___________________

**Permission for Rock Wall**

I give permission for my child ________________________________________ to climb the rock wall at the Riverfront YMCA from June 2, 2025- August 15, 2025.

Parent/Guardian Signature ____________________________________________ Date ______________________

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**Permission to Participate in Swimming Activities**

I give permission for my child to participate in swimming activities near water two feet or more in depth – and/or water activities planned in water two feet or more in depth, including wading pools/splash pads

The center will be providing 1 additional adult above the required staff/child ratio.

| Swim Site | Riverfront YMCA Pool (544 Broad Blvd., Cuyahoga Falls, OH 44221)<br>Wadsworth YMCA Outdoor Pool (623 School Drive, Wadsworth, OH 44281) |
|---|---|
| Date(s) | June2, 2025- August 15, 2025 |
| Departure/Arrival Times from Center | 8:30 am-4:00 pm |
| Mode of Transportation | Pool on site<br>Transportation is provided by school busses (CF City Schools Transportation Services) |
| My child is a | ☐ Swimmer ☐ Non Swimmer |

I give permission for my child to participate in the swimming/water activities listed above:

Child Name: _______________________________________________ Date of birth:_________________

Parent/Guardian Signature ______________________________________ Date ___________________

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**Child Drop-Off/Pick-Up Policy**

When you enroll your child in any YMCA Day Camp, it is to be understood that our policy is for you to bring your child into the center each morning, sign the attendance sheet, and let one of the staff members know your child has arrived. Please note: we are not legally responsible for your child when he/she is dropped off without completing the above procedure.

I understand that state law requires me to sign my child in and out each day, as well as notify staff that my child is leaving for the day.

Parent/Guardian Signature ______________________________________ Date ___________________

## Child/Family Information Form

In an effort to understand your child and to meet their needs, we would like you to complete the following:

Child's Name: ____________________________________________

Who is in the child's immediate family? ____________________________________________

Who lives at home with your child? (pets included) ____________________________________________

What is the primary language spoken in your child's home? ____________________________________________

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.?____________________________________________

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend, or pet) ____________________________________________

____________________________________________

Are there any cultural or religious practices of your family we should be aware of? (dietary restrictions, clothing, head coverings, etc.) ____________________________________________

Has your child had a previous care arrangement? If so, what kind? (Center based, in home, with family, with parents, etc.)

____________________________________________

What causes your child to feel angry or frustrated? ____________________________________________

What methods do you use to respond to your child's negative behavior? ____________________________________________

____________________________________________

Does your child need assistance when using the toilet? If so, how? ____________________________________________

What time(s), and for how long, does your child usually nap? ____________________________________________

What might you and/or your child be anxious about as he/she starts in this program? ____________________________________________

____________________________________________

What are your expectations of this program? ____________________________________________

**Would you like information or referrals for any of the following?**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Food Assistance | | | Help meeting the developmental needs of your child |
| | | Housing | | | Family Counseling |
| | | Nutrition | | | Parenting Education or Information |
| | | Health/Immunizations | | | Dental |
| | | Other: | | | Other: |

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Staff Use:

Referrals Made (date) _______ (to where) ____________________________________________

Follow up (date) _______ (comments) ____________________________________________

Ohio Department of Job and Family Services

# CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

| Child's Name | Date of Birth | First Day at Program/Home |
|---|---|---|
| Home Address | | City |
| State / Zip Code | Home Telephone Number | |

| Parent/Guardian Name #1 | Relationship to Child |
|---|---|
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's |
| City / State / Zip | |
| Email Address *(if applicable)* | Cell Phone *(if applicable)* |
| Parent's Work/School Name | Parent's Work/School Telephone Number |
| Parent's Work/School Address | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

| Parent/Guardian Name #2 | Relationship to Child |
|---|---|
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's |
| City / State / Zip | |
| Email Address *(if applicable)* | Cell Phone |
| Parent's Work/School Name | Parent's Work/School Telephone Number |
| Parent's Work/School Address | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

**Emergency Contacts:** Parents <u>**cannot be listed**</u> as emergency contacts. List the name <u>of at least one person</u> who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

| Name | | Name | |
|---|---|---|---|
| City | State | City | State |
| Telephone Number | Relationship to Child | Telephone Number | Relationship to Child |
| Other numbers where emergency contact can be reached *(if applicable)* | | Other numbers where emergency contact can be reached *(if applicable)* | |

| Name of Physician or Clinic/Hospital | | |
|---|---|---|
| Street Address | | |
| City | State | Telephone Number |

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

| Child's Name |
| --- |
| |

**Diapering Statement**

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

**Emergency Transportation Authorization**

| **Give *Permission* to Transport** | | **OR** Do not sign both | ***Do Not Give Permission* to Transport** | |
| --- | --- | --- | --- | --- |
| Program or Home Name Riverfront YMCA | | | Program or Home Name | |
| **has permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported. | | | **does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken: | |
| Parent's Signature | Date | | Parent's Signature | Date |

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐Yes ☐No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

| Parent/Guardian Signature(s) | Date |
| --- | --- |
| Administrator/Designee Signature | Date |

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| --- | --- | --- | --- |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

# CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

## Part II: Conditions Requiring Medication or Medical Food

**Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

**(If no medications or medical foods are required for the condition, skip Part II).**

**If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.**

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

| Child's Name | Date of Birth | Weight *(if needed to determine dosage)* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| Name of Medication/Medical Food | Name of Medication/Medical Food | Name of Medication/Medical Food |
| Dosage of Medication/Medical Food | Dosage of Medication/Medical Food | Dosage of Medication/Medical Food |
| Time of Medication/Medical Food Administration | Time of Medication/Medical Food Administration | Time of Medication/Medical Food Administration |
| Medication/Medical Food Expiration Date | Medication/Medical Food Expiration Date | Medication/Medical Food Expiration Date |

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

| Physician's Signature | Date of Signature |
|---|---|
| | |

## Part III: Administration of Medication or Medical Food Training Authorization

**Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)**

**Part III must be completed**

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

| **Parent Provided Training** AND grants permission to perform the procedure | **Complete Only One Section** | **Certified Professional Training** AND parent grants permission to perform the procedure |
|---|---|---|
| *My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.* | | *My signature indicates I have provided instructions for care and/or training for the medical procedure* |
| Parent Signature | | Certified Professional's Name *(please print)* |
| Date of Signature | | Certified Professional's Signature |
| | | Date of Signature / Phone Number |
| | | *My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.* |
| | | Parent Signature |
| | | Date of Signature |

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

| Printed Name | Signature | Date |
|---|---|---|
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| *My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.* | Administrator/Provider Signature | Date of Signature |

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
|---|---|---|---|
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |

## Part IV: Documentation of Administration of Medication or Medical Food

**Completed by child care staff member, family child care provider or in-home aide for the child listed on this form**

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

**This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.**

| Child's Name | Name of medication/medical food |
| --- | --- |
| | |

| Date | Time | Dosage | Signature of designated person administering medication |
| --- | --- | --- | --- |
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