St. Olaf Preschool & Kindergarten
Disaster Pack Information Form

Child's Name_____Birthdate_____

My child is in need of medication within a 24-hour period. (please circle) YES NO

If yes, please provide us with the medication .

Medication_____Dosage_____Time_____

Medication_____Dosage_____Time_____

I authorize St. Olaf staff to administer the above medication in the event of a disaster and release them of all liability.

Parent Signature_____Date_____

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONSENT FOR EMERGENCY MEDICAL TREATMENT
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

ST. OLAF CHILDCARE CENTER TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
CHILD'S NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE

CHILD NAMED ABOVE.

_____
DATE & PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

LIC 627 (9/08) (CONFIDENTIAL)