ODYSSEY CHILDCARE MEDICAL TRAINING CONFIRMATION FORM

PARENT NAME: _____

CHILD NAME: _____

LIST ANY ALLERGIES: _____

HAS YOUR CHILD SUSTAINED ANY INJURIES: YES: _____ NO: _____

PLEASE LIST INJURIES: _____

_____

_____

_____

NAME OF CONDITION OR DIAGNOSIS: _____

PLEASE DESCRIBE CONDITION OR DIAGNOSIS: _____

_____

_____

_____

IS YOUR CHILD ON ANY MEDICATIONS: YES: _____ NO: _____

DORCTOR WHO PRESCRIBED MEDICAITON: _____

PHARMACY TO CONTACT IF NEEDED: _____

PLEASE LIST MEDICATIONS: _____

_____

INSTRUCTIONS FOR HANDLING AND ADMINISTERING OF MEDICATIONS: _____

_____

_____

_____

SPECIFIC INSTRUCTIONS ON CARING FOR YOUR CHILD: _____

_____

_____

_____

(This may include supports for eating, toileting, movement, special exercises, any developmental support devices your child requires to have in the day home and special instructions for them, behavioral support, speech support, etc.)

TRAINING REQUIRED: YES: _____ NO: _____

TYPE OF TRAINING: _____

TRAINING PROVIDED BY: _____

DATE TRAINING COMPLETED: _____

PROVIDER INPUT: _____

_____

_____

_____

DATE CONTRACT SIGNING: _____

SIGNATURES:

PARENT SIGNATURE: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____

AGENCY SIGNATURE: _____ DATE: _____