

# West Bend Mallard Little Rines' Early Childhood parent permission

Please initial and mark yes or no under each permission agreement.

## Sunscreen Permission:

I give permission for the West Bend Mallard Little Rines' staff to apply sunscreen to my child. If my child has an allergy to a certain sunscreen, I will provide sunscreen for my child if I wish to have it applied. Parent initials: \_\_\_\_\_

## Insect Repellent:

When public health authorities recommend the use of insect repellents due to a high risk of insect-borne disease, only repellents containing DEET are used. Staff can only apply insect repellent no more than once a day and only with written parental permission. Parents must provide the insect repellent to the school. Parent initials: \_\_\_\_\_

## Field Trips:

I give my permission for my child to go on field trips while in attendance at the Little Rines' Preschool program. I understand my child may be riding on a West Bend Mallard school bus or the Care Age van from West Bend Health and Rehab. My child will be supervised by a WBM staff member at all times. *(If No is marked, the child will need not be able to attend school the day of the scheduled field trip.)*

Yes \_\_\_\_\_ No \_\_\_\_\_ Parent initials: \_\_\_\_\_

## Photo permission:

I give permission for my child to be photographed/videotaped for use in our Little Rines' Early Childhood program. (Photo may be printed in WB Journal or other newspaper)

Yes \_\_\_\_\_ No \_\_\_\_\_ Parent initials: \_\_\_\_\_

## Emergency treatment:

I give permission for my child to receive emergency treatment (CPR/first aid) by a qualified West Bend Mallard staff member. This permission includes transportation by an ambulance if needed. In an event that I can't be contacted, I give consent to dental, medical and hospital professionals to treat my child if necessary for the safeguard of my child's health. In case of an emergency, I agree to pay all costs of treatment and transportation.

Yes \_\_\_\_\_ No \_\_\_\_\_ Parent initials: \_\_\_\_\_

## Health file access:

I give permission for any West Bend Mallard staff or AEA personnel to access my child's personal health file at school. Yes \_\_\_\_\_ No \_\_\_\_\_ Parent initials: \_\_\_\_\_

**By signing this permission agreement, I agree to the statements listed above.**

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

