

West Bend Mallard Little Rines' 4 year old Preschool 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 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 to and 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' Preschool 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:** _____