

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC & BEHAVIORAL HEALTH
CHILD CARE LICENSING

LAS VEGAS OFFICE

☐ 3811 W. Charleston Blvd. Ste. 210
Las Vegas, NV 89102
Phone: 702-486-3822 Fax: 702-486-6660

ELKO OFFICE

☐ 1010 Ruby Vista Dr., Suite 101
Elko, Nevada 89801
Phone: 775-753-1237 Fax: 775-753-1336

CARSON CITY OFFICE

☐ 727 Fairview, Suite E
Carson City, Nevada 89701
Phone: 775-684-4463 Fax: 775-684-4464

Parent/Guardian Notification of NRS.178 Child Care Facility required to maintain certain information; reporting of information to parents and guardians; notice of right to information:

I, _____, (Parent/Guardian) am aware that I have the right to request and review any complaints the facility has received within the last 12 months of my child's(ren's) enrollment.

Signature of enrolling Parent/Guardian

Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC & BEHAVIORAL HEALTH
CHILD CARE LICENSING

LAS VEGAS OFFICE

☐ 3811 W. Charleston Blvd. Ste. 210
Las Vegas, NV 89102
Phone: 702-486-3822 Fax: 702-486-6660

ELKO OFFICE

☐ 1010 Ruby Vista Dr., Suite 101
Elko, Nevada 89801
Phone: 775-753-1237 Fax: 775-753-1336

CARSON CITY OFFICE

☐ 727 Fairview Drive, Suite E
Carson City, Nevada 89701
Phone: 775-684-4463 Fax: 775-684-4464

PARENT FORM

COMPLAINTS AGAINST _____
(Facility Name)

Month / Year	Complaint	Findings of Investigation	Disciplinary Action Taken	Parents notified within 3 days. Documentation Attached

MEDICATION REQUEST

I am requesting that the following medication be administered to my child. I have provided a prescription for this medication (even if it is over the counter), it is in its original container with a child proof lid, and it is labeled with the name of my child.

Child's Name: _____ Medication Name/Dosage: _____

Dates to be given: _____ Times to be given: _____

<u>DATE/TIME</u>	<u>MEDICATION/DOSAGE</u>	<u>PERSON ADMINISTERING</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent Signature: _____ Date: _____

Staff member who has been trained with administering medication: _____

Training provided by: _____ Date: _____

MEDICATION REQUEST

I am requesting that the following medication be administered to my child. I have provided a prescription for this medication (even if it is over the counter), it is in its original container with a child proof lid, and it is labeled with the name of my child.

Child's Name: _____ Medication Name/Dosage: _____

Dates to be given: _____ Times to be given: _____

<u>DATE/TIME</u>	<u>MEDICATION/DOSAGE</u>	<u>PERSON ADMINISTERING</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent Signature: _____ Date: _____

Staff member who has been trained with administering medication: _____

Training provided by: _____ Date: _____

Revised 8-2-00

Dear Physician: _____
(Child's Name)

is enrolled in a family child care home which is licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one (1) year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone #: _____

Name of Parents: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance:

Has this child been screened for lead poisoning? Yes _____ No _____

(*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care educator? If so, please detail below.

Physician's Signature: _____ Date: _____

Comments: _____

Please return this form and the child's immunization record to:

