Stow & Woodridge Before and After School Enrichment
General Information 2024-2025

Care Site & License #	Schools Served	Location	Times
Echo Hills YMCA BASE 106352	Echo Hills	Echo Hills Elementary 4405 Stow Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Fishcreek YMCA BASE 106353	Fishcreek	Fishcreek Elementary 5080 Fishcreek Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Highland YMCA BASE 106351	Highland Lakeview	Highland Elementary 1843 Graham Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Indian Trail YMCA BASE 100411	Indian Trail	Indian Trail 3512 Kent Rd Stow, 44224	7:00-9:00am 3:30-6:00pm
Riverview YMCA BASE 100414	Riverview	Riverview Elementary 240 North River Rd. Munroe Falls, Ohio 44262	7:00-9:00am 3:00-6:00pm
Woodland YMCA BASE 100270	Woodland	Woodland Elementary 2908 Graham Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Woodridge YMCA BASE 102536	Woodridge	Woodridge Elementary 4351 Quick Rd., Cuyahoga Falls, 44223	7:00-8:30am 3:00-6:00pm

*Your child's **completed** packet must be turned in to the YMCA at least two business days before your child can start care.

Before and After School Enrichment Fees

$40.00 registration fee waived if enrolled before July 15th, 2024

Weekly, Flat-rate Fees (Stow and Woodridge)

- Full Time: 3 days or more of care
- Part Time: 2 days or less of care

Cancellation notification must be given no later than one week in advance.

There are no sibling discounts.
Program subject to change.

Program	Stow School District		Woodridge School District	
	Y Member Rate	Non-Member Rate	Y Member Rate	Non-Member Rate
Before Care Only	$ 62.00	$ 70.00	$ 62.00	$ 70.00
After Care Only	$ 70.00	$ 80.00	$ 70.00	$ 80.00
Before AND After Care	$ 95.00	$ 105.00	$ 95.00	$ 105.00
Before OR After Care, daily rate	$ 25.00	$ 25.00	$ 25.00	$ 25.00
Before AND After Care, daily rate	$ 35.00	$ 35.00	$ 35.00	$ 35.00
Registration Fee	$ 40.00	$ 40.00	$ 40.00	$ 40.00

Before and After School Enrichment General Information 2024-2025 (cont.)

Parent Handbook – The "Riverfront YMCA Child Care Parent Handbook" is available at the following link:
https://www.akronymca.org/locations/riverfront-ymca/and-after-school
A paper copy will be provided upon request.

KEEP THIS PAGE!

Directors – Please feel free to contact a director with questions or concerns.

Laura Davisson – Woodridge Elem.
(330) 923-9622
Laurad@akronymca.org

Grace Cominsky – Stow Schools
(330) 923-9622
Gracec@akronymca.org

Publically Funded Child Care Recipients (PFCC) – Your TAPs authorization must be for the correct location. The YMCA and each Before and after School site is considered a different location to ODJFS. Please be sure to change locations for Fun Days/Snow Days to license 301735. Please see above for each location's Licensing Number.

To apply for Publicly Funded Child Care (PFCC), please scan the QR Code to be taken to the ODJFS website. If you are denied, the YMCA may be able to help you with the cost of child care, please contact the director of your school district.

Medications/Medical Conditions – We do not allow medications to be stored in the school nurse's office. In order for the YMCA to provide safe care to your child, we must have additional medication stored in our care, at our Before and After school sites. We will not accept medication left in the school nurses office as we cannot guarantee access to it. Inhalers/diabetes medications may be brought with your child, however they must be kept on your child's person, not in a backpack. Before turning in your child's packet, please contact a director to obtain JFS01236 and/or JFS01217 if your child requires the form.

Fun Days – You may drop off your child as early as 7:00am and your child must be picked up by 6:00pm. Pre-registration is required, a form for each Fun Day must be filled out and submitted to the YMCA or BASE staff. Forms will be available two weeks prior to each Fun Day at the YMCA front desk and BASE sites – there is also a blank form on our website. Each Fun Day costs $45 per day per child for BASE participants or YMCA members, and $50 per day per child for non-Base participants or non-YMCA members. Registration is on a first come first serve basis. Fun Day Calendar can be found at:
https://www.akronymca.org/locations/riverfront-ymca/fun-day

Snow Days – In the event of a Snow Day, care is provided at the Riverfront YMCA from 8:30am-6:00pm. Your child must be pre-registered for Snow Days in order to attend. Snow Day sign-up slips will go out to Before and After care sites in November. If registering your child after November, please contact a Youth Enrichment Director for assistance in signing up for Snow Days.

Early Release – There is no After Care for Early Release days.

Early release Days (No After Care, Morning Care only)
Stow: 10/18/2024 & 3/14/2025

School Year Start and End Dates
Stow: 8/22/2023-6/3/2025
Woodridge: 8/14/2024-5/22/2025

Program and dates subject to change.

Riverfront YMCA Stow & Woodridge Before and After School Enrichment 2024-2025

Please check all types of care you will need

☐ Before Care ☐ After Care Anticipated Start Date:_____

☐ Full Time ☐ Part Time

If Part Time, what day/s? _____

Registration Fee:

A non-refundable $40 registration fee is due at time of registration.

Payment: ☐ Draft from debit/credit card on file (ending in____)

Payment Information:

Please draft payment: ☐Weekly on Fridays ☐Other (contact Director)

Account: ☐Account on file (ending in ____) ☐FLEX (contact Director)

Person Responsible for tuition:_____

Do you have Publicly Funded Child Care (PFCC) (formerly known as Title XX)? ☐Yes ☐No

Child's Name and Nick Name _____ ☐ male ☐ female

Child's Birth date _____ Age _____

Street Address _____

City _____ State _____ Zip_____

School Child Attends_____ Grade_____

YMCA Member? ☐ yes ☐ no

Parent Name_____

Primary Number ( ) ☐ C ☐ H ☐ W

Secondary Number ( ) ☐ C ☐ H ☐ W

Email _____

Birth date _____

YMCA Employee? ☐ yes ☐ no

Parent Name _____

Primary Number ( ) ☐ C ☐ H ☐ W

Secondary Number ( ) ☐ C ☐ H ☐ W

Email _____

Birth date _____

YMCA Employee? ☐ yes ☐ no

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require a government issued identification before releasing your child.

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Please note: if there are any custody issues involved with your child, you must provide the center directors with full court papers including who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation.

****If you receive publically funded child care, all authorized persons to pick up will be required to use the mobile TAPs system.****

Child's name _____

2024-2025 Center Policies Agreement

Please read the policies carefully and **initial** all lines.

_____ I understand there is a $40 non-refundable registration fee per child.

_____ Weekly tuition is due on Fridays prior to the week of service via auto draft.

_____ I understand that if my childcare payments fall one week behind I will be asked to withdraw my child until payment is made.

_____ Outstanding balances of $100 or more that are past 30 days in arrears will be turned over to collections.

_____ I understand that if I have any outstanding balance at any facility within the Akron Area YMCA Association I am unable to register for any programs or membership until balance is paid.

_____ I understand that there will be a $10 fee assessed for any and every returned payment.

_____ CANCELLATION POLICY: Notification must be given no later than one week in advance. Otherwise, I understand that I will be responsible to pay that week's tuition in-full, regardless of attendance.

_____ I understand that late pick-up fees in the amount of $15 for every 15 minute increment per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:00 pm).

_____ I understand that staff will contact Summit/Medina County Children Services if my child remains at the center longer than one hour after closing and all attempts to reach me, the child's other parent, and authorized persons have been made, without success.

_____ I understand that state licensing requires that all forms in this registration packet must be completely filled out and turned in prior to the child's admission to the program.

_____ I understand that I am required to disclose all medical, physical, or behavioral issues that pertain to my child at the time of enrollment, and supplement that information on an ongoing basis as needed.

_____ I have read the YMCA BASE/Day Camp Registration Packet and Parent Handbook (which can be found on our website at https://www.akronymca.org/locations/riverfront-ymca/and-after-school) and agree to all terms therein for my child(ren) to receive childcare. I understand that I forfeit the privilege of childcare if all policies are not followed.

FOR PUBLICALLY FUNDED CHILD CARE RECIPIENTS ONLY

_____ I understand that my Publically Funded Child Care co-pay is due every Friday via auto draft prior to care.

_____ I understand that if my Publically Funded Child Care authorization is not current and/or not for the correct location, I will be responsible for private pay rates.

_____ I understand that I must tap using a mobile device daily. I understand there is a back date period if daily taps are missed. If I miss the back tap period, I understand that I will be charged the difference between my co-pay and the weekly private-pay rates. I understand it is my responsibility to know for which dates and times I need to back date.

Parent/Guardian Signature _____ Date _____

Permissions

Photograph Consent

☐ I give my child _____ permission to be in photographs, slides, or videotapes for promotion of the Akron Area YMCA.

☐ I do not give my child _____ permission to be in photographs, slides, or videotapes for promotion of the Akron Area YMCA.

Parent/Guardian signature: _____ Date: _____

Program Waiver

I understand that there is a risk of serious injury associated with the use of the YMCA facilities, participation in YMCA programs and use of exercise and other equipment. As a condition of my membership I agree to assume the risk of injury arising from my use of the facilities, programs, equipment, and for all other matters at all YMCA locations or programs whenever occurring. On behalf of myself and my heirs, administrators and agents and contractors harmless from all such claims for injury and damage. I understand that I would not be permitted to participate in any YMCA program or use any YMCA facility or equipment without signing this agreement.

Parent/Guardian signature: _____ Date: _____

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Before and After School Enrichment program, it is to be understood our policy is for you to bring your child into the center each morning, sign and list the arrival time on the sign in sheet, and let one of the staff members know your child has arrived. Please note, we are not legally responsible for your child when he/she is dropped off without completing the above procedure.

I understand state law requires me to sign my child in and out each day as well as notify staff that my child is leaving.

Parent/Guardian signature: _____ Date: _____

FUN DAYS

Permission to Participate in Swimming Activities - *Fun Days*

I give permission for my child _____ to participate in swimming activities near water two feet or more in depth – or water activities in water two feet or more in depth.

The center will be providing two (2) additional adults above the required staff/child ratio.

Swim Site	Riverfront YMCA Swimming Pool
Date(s)	Fun Days (August 2024-May 2025)
Departure/Arrival Times from Center	On site, 9:00-3:00pm
Mode of Transportation	Walking in building to indoor pool facility
My child is a	☐ Swimmer ☐ Non Swimmer

Parent/Guardian Signature _____ Date _____

Permission for routine walks – *Required for Fun Days*

Weather permitting, I give permission for my child _____ to accompany their group on routine walks to DeWitt Playground. The playground is located at 425 Falls Ave., Cuyahoga Falls, OH 44221

Child/Family Information Form

In an effort to understand your child and to meet his/her needs, we would like you to complete the following:

Child's Name: _____

Brothers and sisters (names and ages):

_____

Child lives with:

_____

How did you hear about the program? _____

What is the primary language spoken in your child's home? _____

Does your child have any particular fears such as dogs, storms, etc.?

_____

What are your child's special interests?

_____

_____

Have there been any changes or transitions in your child's life recently, such as divorce, new home, death, etc.?

_____

_____

Are there additional personality and behavior characteristics that would be useful to know about your child?

_____

_____

How do you reassure or reward your child?

_____

_____

How do you discipline your child?

_____

_____

Please list the three most important things you would like your child to work on while in our program:

_____

_____

What other information would be helpful for the staff caring for your child to know?

_____

_____

Ohio Department of Job and Family Services

DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

Name of Child	Date of Birth

For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Lead Teacher's Name	Signature	Date

Parent/Guardian's Signature	Date

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home
Home Address			City
State	Zip Code	Home Telephone Number	
Parent/Guardian Name #1		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone *(if applicable)*	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		**OR** Do not sign both	***Do Not Give Permission* to Transport**	
Program or Home Name Riverfront YMCA			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication