KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

Dear Family,

Thank you for choosing Kinderberry Hill! We are excited to welcome your family to our school. As we begin to prepare things for your child's first day, please take a few moments to complete the enclosed paperwork which are required by the State of Minnesota. The following forms are to be completed in their entirety before your child can attend their first day at Kinderberry Hill.

- Emergency Card: This provides emergency contact information in the event we cannot reach parents/guardians. Two emergency contacts are required and they must be different from the parents/guardians listed above.
- Standing Order for Non-Prescription, Over-the-Counter Products: On this form you will designate which non-prescription medications/products you will allow Kinderberry Hill staff to administer to your child. All of the non-prescription medications listed must be provided by the parent/guardian, unless otherwise noted. The parent/guardian must also give verbal permission before any non-prescription medication is administered. Please mark each item with an "x".
- Health Assessment Consent Form: This form gives Kinderberry Hill nurse permission to evaluate child, should symptoms warrant such an evaluation. Examples might include: using an otoscope to check ears, stethoscope to listen to lungs, and/or pulse oximeter to assess oxygen levels. Our nurses can assess and make recommendations, but they cannot make a formal diagnosis.
- Health Assessment, Immunization Record, Dosing Chart, and Infant Food Recommendations- These forms are to be completed by your child's pediatrician. Please allow 7-14 days for completion.
  **All children enrolled at Kinderberry Hill must be immunized according to the schedule provided by the Minnesota Department of Health.*
- Allergies or Special Food Needs: This documents any allergies or special food needs as determined by a physician or religious preference. Should your child have any diagnosed allergies, separate paperwork must be completed by their physician.
- Child Development Form: This form provides Kinderberry Hill staff with more specific information and insight about your child.
- Health Insurance Information: Should an emergency situation arise, your health insurance information will be given to seek appropriate medical attention.
- Parental Authorization for Pick-Up: Please list the names and phone numbers of the individuals authorized to pick-up your child when you are unavailable. Photo I.D. will be required at the time of pick-up.
- Enrollment Contract: This form states the terms and conditions of enrollment.
- Tuition Express Authorization Form: Please complete this form in order to make monthly payments online or have payments auto-withdrawn each month. Banking information is required for both payment options.

If you have any questions regarding the enclosed paperwork, please feel free to contact us. We look forward to getting to know your child and family!

Sincerely,

Executive Program Director

Operations Coordinator

EMERGENCY CARD

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

CHILD'S NAME		BIRTH DATE	
ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN INFORMATION

1		
HOME PHONE	MOBILE PHONE	WORK PHONE
2		
HOME PHONE	MOBILE PHONE	WORK PHONE

THE FOLLOWING INFORMATION IS REQUIRED BY THE DEPARTMENT OF HUMAN SERVICES

EMERGENCY CONTACT/AUTHORIZED PICK UP
***(MUST BE DIFFERENT FROM PARENT/GUARDIAN)**

1	NAME			
	RELATIONSHIP		PHONE NO.	
	ADDRESS	CITY	STATE	ZIP
2	NAME			
	RELATIONSHIP		PHONE NO.	
	ADDRESS	CITY	STATE	ZIP
PHYSICIAN			PHONE NO.	
ADDRESS		CITY	STATE	ZIP
PREFERRED HOSPITAL				
ALLERGIES				
DENTIST			PHONE NO.	
ADDRESS		CITY	STATE	ZIP
MEDICATIONS				
OTHER SIGNIFICANT MEDICAL INFORMATION				

I give permission to Kinderberry Hill to make whatever emergency (e.g., first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the center.

In case of a medical/dental emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource (police, rescue squad) deems it necessary. It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

By signing this form, I authorize Kinderberry Hill to release any information pertaining to my child to persons listed as an emergency contact or authorized pick up.

SIGNATURE_____ DATE_____
PARENT OR GUARDIAN

KINDERBERRY HILL
CHILD DEVELOPMENT FORM

Child's Full Name	Does your child have a nickname?
First Name(s) of Parent(s) or Guardian(s):	
Number of siblings in home:	Ages of siblings in home:
List anyone else presently living in the home:	
Please list the language(s) spoken in your home:	

GENERAL HISTORY

1. Has your child had previous child care experience? ☐ YES ☐ NO

   If yes, please list location(s) of previous child care experience:

   _____

   _____

2. Is your child ☐ left-handed or ☐ right-handed? ☐ N/A – has not been developed yet

3. What is your child's favorite toy(s)? _____

4. What is your child's favorite play activity? _____

5. Special interests of your child:

   _____

6. What do you think would be the best way for our teachers to support your child?

   _____

7. Is your child taking any medications now? ☐ YES ☐ NO

   If yes, what? _____

8. Is your child receiving or eligible for Developmental Disability (DD)-related case management services? ☐ YES ☐ NO

   Please contact your school's management team to discuss accommodations, expectations, or inform them if services will impact daily care at Kinderberry Hill. It is important that families and schools be on the same page in determining whether Kinderberry Hill is the best fit for your child and family.

EMOTIONAL BEHAVIOR

1. Every child, at one time or another, exhibits the behaviors listed below. Please indicate which words you feel are ***most*** applicable to your chlid:

☐ Generally Cheerful	☐ Physical	☐ Sensitive	☐ Quiet
☐ Calm	☐ Active	☐ Talkative	☐ Easily Excited
☐ Independent	☐ Group Leader	☐ Outgoing	☐ Often Shy
☐ Cooperative	☐ Group Follower		

2. List other comments you may have regarding your child's behavior:

_____

_____

3. What behavior do you consider most difficult to deal with?

_____

_____

4. How do you comfort your child? (i.e., use of pacifier, blanket, stuffed animal, physical touches such as hugs, etc.)

_____

5. Is there anything we as teachers should know about your child to help us work with him/her more effectively: (Please include cultural preferences)

_____

_____

6. What do you feel that we as teachers can do for your child?

_____

_____

7. Does your child have any physical, emotional, or medical needs the staff should be aware of? Yes ☐ No ☐
Please attach a copy of your child's IEP, if applicable.

   If yes, please explain.

_____

HEALTH NEEDS

1. Does your child have any allergies? Yes ☐ No ☐

   If yes, please list your child's allergies. How does your child react?

   _____

   _____

   _____

2. Does your child have any food allergies or special food needs? Yes ☐ No ☐

   If yes, please describe?_____

   _____

   Please list any necessary treatment on form KBH-121. (Allergies or Special Food Needs)

DAILY ROUTINES

INFANTS

Please place a check by your child's daily nutritional intake:

☐ breast milk ☐ formula ☐ baby food ☐ table food

What type of formula are you using? _____

What type of bottles are you using? _____

Does your child have any special feeding requirements? Yes ☐ No ☐

If yes, please describe: _____

What is your child's present eating schedule?

Breakfast: _____ Morning Snack: _____ Lunch: _____ Afternoon Snack: _____

What is your child's present sleeping schedule?

Night Time: _____ to _____ Morning Nap: _____ to _____ Afternoon Nap: _____ to _____

Does your child use a pacifier?	Yes ☐	No ☐
Do you have any special ways of helping your child go to sleep? If yes, what?	Yes ☐	No ☐

TODDLER – INTERMEDIATE - PRESCHOOL			
Is your child toilet trained? What words does your child use for urination? _____ What words for bowel movement? _____	Yes ☐	No ☐	N/A ☐
What is your child's present sleeping schedule? Night Time: _____ to _____ Afternoon Nap: _____ to _____			
Do you have any special ways of helping your child go to sleep? If yes, what?	Yes ☐	No ☐	
Does your child need a blanket or toy for sleeping?	Yes ☐	No ☐	

Other than the Kinderberry Connect app, what is the best way to communicate with you?

_____

Which family member should we reach out to first should anything arise during the day?

_____

Is there any other information about your child or your family that you feel is important for us to know in order to give the very best care to your child?

_____

_____

_____

_____

Parent/Guardian Signature	Date

HEALTH ASSESSMENT CONSENT FORM

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

Child's Name	Date of Birth
Parents' Names (please print)	Center Location

Kinderberry Hill employs an onsite nurse. One of the nurse's roles is to help ensure the health and safety of each child by utilizing their professional skills to monitor and assess your child should they become ill or express discomfort at the center. While this may include basic assessments such as monitoring vital signs, the nurse also has ability to conduct a more advanced assessment. This may include listening to lung and bowel sounds, looking in ears to check for redness, and the evaluation of blood oxygen levels using a fingertip pulse oximeter.

If you would like the Kinderberry Hill nurse to perform any of the advanced assessments listed above (should symptoms warrant a closer evaluation), please give your consent by signing below.

- ○ I give my consent to have the Kinderberry Hill onsite nurse evaluate my child through an advanced assessment, should symptoms warrant such an evaluation.
- ○ I do not give my consent to have the Kinderberry Hill onsite nurse evaluate my child through an advanced assessment.

Parent Signature	Date

AUTHORIZATION & STANDING ORDER FOR NON-PRESCRIPTION/ OVER-THE-COUNTER PRODUCTS

I authorize the nurse or other designated Kinderberry Hill staff to administer the non-prescription, over-the-counter products indicated below to:

Child's Name:	
Child's Age:	Child's Weight:

Please note that parents are to provide any of the following non-prescription medications, or other items listed below. Kinderberry Hill does not provide these products, except where indicated; parent permission is required for all products Kinderberry Hill provides and may administer to your child.

Please check all that apply.

☐ Acetaminophen or Ibuprofen (weight appropriate dosage) for an axillary temperature over 100°F and/or for any physical discomfort. ***Kinderberry Hill will refer to the recommended dosage noted on the medication's packaging; a written authorization from a physician must be obtained for all children under the age of two stating the recommended dosage for the child (Form KBH-200).**

☐ Antihistamine (Benadryl) for allergic reactions. ***Kinderberry Hill will refer to the recommended dosage noted on the medication's packaging; a written authorization from a physician must be obtained stating the recommended dosage for the child (Form KBH-200a).**

☐ Pre-Moistened Wipes **(provided by Kinderberry Hill)**. Parents may provide their own pre-moistened wipes if your child has sensitive skin, or is allergic to the product we use.

☐ Diaper Cream (A&D Ointment, Desitin, Balmex, Burt's Bees Diaper Ointment, Boudreax's Butt Paste, Triple Paste, Aquaphor, etc.) Must be a store-bought brand in original container. No homemade versions.

☐ Sunscreen **(provided by Kinderberry Hill).** Kinderberry Hill's sunscreen has an SPF of 30 and is PABA-free. Please speak to your director if your child has sensitive skin, or is allergic to the product we use.

☐ Insect repellent. (Only repellents containing DEET are allowed to be used and will be applied once per day to children two months or older.)

☐ Non-alcohol based hand sanitizer **(provided by Kinderberry Hill)**.

☐ Boogie Wipes **(provided by Kinderberry Hill)**.

☐ Toothpaste **(provided by Kinderberry Hill). Kinderberry Hill will provide a fluoride free toothpaste.**

☐ Others (lotion, lip balm, toothpaste):
_____

Parent's Signature:	Date:

ALLERGIES OR SPECIAL FOOD REQUESTS

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

Child's Information:

Parent or guardian must complete; please print.

Child's Name:			
Center Attending:			Date of Birth:
Parent/Guardian Name:	Home Phone Number:		Work Phone Number:
Parent/Guardian Address:	City:	State:	Zip Code:

1. My child does have food or environmental allergies, asthma, or special food accommodations as determined by a physician or religious preferences.

◯ Yes ◯ No **If yes, please continue on to question 2.** If no, please sign and date below.

Parent Signature:	Date:

2. My child has (please check all that apply): ***NOTE: Executive Program Director will provide all additional forms listed below.**

☐ Food Allergies ☐ Environmental Allergies

If checked, please fill out form #KBH-121a-Individual Allergy Action Plan, along with appropriate prescription and non-prescription medication release forms: #114a-Long-Term Prescription Medication Release and #200a-Authorization for Over-the-Counter Allergy Medication.

3. My child has Asthma.

◯ Yes ◯ No

If yes, please fill out form #KBH-121b-Individual Asthma Action Plan, along with appropriate prescription and non-prescription medication release forms (#114a-Long-Term Prescription Medication Release).

4. My child has special diet accommodations (cultural/religious preferences).

◯ Yes ◯ No

If yes, please fill out form #KBH-121c.

Parent Signature:	Date:

PARENTAL AUTHORIZATION

FOR PICK-UP AND MEDICAL/ HEALTH INFORMATION ACCESS

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

For the protection of your child and in any emergency situation which may arise, please list below the names and phone numbers of those persons you hereby authorize to pick up your child from the center. Kinderberry Hill will only release your child to adults you designate as authorized. It is our policy to ask all unfamiliar adults for photo identification.

Child's Name (First, Middle, and Last)

NAME	PHONE NUMBER	RELATIONSHIP TO CHILD

Signature of Parent/Guardian	Date

PASS CODE

In order to release your child to individuals not listed on this form, Kinderberry Hill requires a confidential pass code that will be stored in a secure location and only available to selected personnel. In the event you or one of the authorized persons are unable to pick up your child, do you want Kinderberry Hill to accept a telephone authorization using your confidential pass code?

◯ Yes ◯ No

Pass Code:	
Signature of Parent/Guardian	Date

Tuition Express Authorization Form

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

I authorize the following account payment option (check one):

❒ Parent Initiated Payments

Each payment must be initiated by you, the payor. Kinderberry Hill will store your banking information in an encrypted, electronic manner to allow efficient payments and protect against the risks of manually entering this information for each payment.

❒ Auto Payments

Payments will be made for the balance of my account on a monthly basis from the account listed below.

Banking information is REQUIRED for both payment options

If a payment is returned to my bank for any reason, Kinderberry Hill will exercise its rights to represent my payment and the stated returned check fee to my financial institution up to 3 times as permitted by law. Kinderberry Hill's collection agency will attempt to collect the amount of the failed checking or savings payment, along with the return check fee. The return check fee is the amount permitted by state law, or in the absence of such a state law, a fee of $30 may apply.

I understand that I am in full control of my payment, and if at any time I decide to make any changes or discontinue this service, I will notify my school in writing. This authorization will remain in full force and in effect until Kinderberry Hill has received such notification from me of the termination of my authorization in such time and in such a manner as to afford Kinderberry Hill and my financial institution a reasonable opportunity to act on it. Change of payment method will not affect the terms of my contract.

I authorize _____ to make these payments on my behalf.
Financial Institution

_____ _____
First and Last Name of Child(ren) Enrolled Signature

_____ _____
Address Printed Name

_____ _____
City Date

_____ _____ _____
State Zip Account Holder's Phone #

Choose One:

❒ Checking Account Transfer (voided check must be attached)

❒ Savings Account Transfer: Routing # _____ Account # _____

Bank Name:_____

HEALTH INSURANCE INFORMATION

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

Child's Name:	Kinderberry Hill Center:
Parent's Name(s):	Address:
Phone number:	
Insurance Company:	Group Number:
ID Number:	Name of Primary Insurer:

Parents are notified immediately if an illness or injury requires immediate medical attention. In an emergency situation, we contact 911 first and then contact the family. We only use the insurance information provided in the case of an emergency.

HEALTH ASSESSMENT

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

****TO BE COMPLETED BY PHYSICIAN****

Child's Name	Birth Date
Address	Phone
Height (Percentile)	Weight (Percentile)

Physical Findings
A-*Abnormal*
N-*Normal*
Circle One

			Comments				Comments
Head	A	N		Cardiovascular	A	N	
Face	A	N		Abdomen	A	N	
Neck	A	N		Genitals	A	N	
Eyes	A	N		Extremities	A	N	
Ears	A	N		Joints	A	N	
Nose	A	N		Muscle Tone	A	N	
Mouth	A	N		Skin	A	N	
Throat	A	N		Neurological	A	N	
Chest	A	N		Vision	A	N	
Spine	A	N		Hearing	A	N	

Lab Findings

Hemoglobin/ Hematocrit	Urinalysis	Sickle Cell	Blood Lead	Mantoux	Other

Subjective Assessment (Infants Only)

Birth History (*please note significant information regarding premature birth, injury, etc.*)

Feeding/Nutrition (*Recommendations for the following)*

Breast	Amount	Frequency	
Formula	Type	Amount	Frequency

Solids: Type/Amount

Nutritional Supplements

Emergency Care

Does this child have allergies? Yes | No

Reaction

Recommendation

Is this a condition that may result in an emergency?

Emergency plans

Important Health Problems

Problems	Followed by	Requires special attention in child care

How long have you been seeing this child?

Is a special diet necessary?	Yes	No

If yes, specify

Is this child developing normally for his/her age?	Yes	No

If not, what modifications in the child care program are needed?

Additional comments

For Our Records

Name of clinic (if applicable) Phone

Address

Physician's signature Date Exam Date

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

Dear Physician:

According to the State of Minnesota Rule 3 Licensing Requirements for Child Care Centers (Section 9503.0140, Subparagraph 7) non-prescriptive medicines must be administered according to the manufacturer's instructions. In the case of most common non-prescriptive medicines, the manufacturer's instructions indicate that a physician must advise dosages for children under the age of two.

To meet the State's requirement, and make it convenient for parents, Kinderberry Hill is requiring parents to have their physician sign a letter outlining recommended dosages for Children's Tylenol (acetaminophen), and Children's Motrin (ibuprofen). Kinderberry Hill will keep this letter in the child's file and refer to it as needed. Kinderberry Hill also keeps a record of the dosage and the time medication is administered for each child as required by the State. Kinderberry Hill will refer to the recommended dosage noted on the medical packaging; for all children under two years of age, a written authorization from a physician must be obtained stating the recommended dosage for the child.

If there are any questions regarding this request, please contact Kinderberry Hill. Please feel free to approve the following dosage charts or supply your own. Thank you.

MEDICATION			INFANT DROPS	INFANT ORAL SUSPENSION	CHILDREN'S LIQUID
Acetaminophen	**Weight**	**Age**	80 mg/0.8 ml 1 dropper = 0.8 ml	160 mg/5 ml 1 dropper = 5 ml	160 mg/5 ml (1 tsp)
*Dose may be given every 4 hours. Do not use more than 5 times in 24 hours.	6-11 lbs.	0-3 mo.	0.4ml	1.25 ml	1/4 tsp (1.25 ml)
	12-17 lbs.	4-11 mo.	0.8 ml	2.5 ml	½ tsp (2.5 ml)
	18-23 lbs.	12-23 mo.	1.2 ml (0.8+0.4)	3.75 ml	¾3/4 tsp (3.75 ml)
	24-35 lbs.	2-3 yrs.	1.6 ml (0.8+0.8)	5 ml	1 tsp (5 ml)
	36-47 lbs.	4-5 yrs.	-	-	1 ½ tsp (7.5 ml)
	48-59 lbs.	6-8 yrs.	-	-	2 tsp (10 ml)
MEDICATION			**INFANT DROPS**		**CHILDREN'S LIQUID**
Ibuprofen	**Weight**	**Age**	50 mg/1.25 ml 1 dropper = 1.25 ml	-	100 mg/ 5 ml (1 tsp)
*Dose may be given every 6 to 8 hours. Do not use more than 4 times in 24 hours. *Ask your healthcare provider before giving ibuprofen to a child less than 6 months old.	12-17 lbs.	6-11 mo.	1.25 ml	-	½ tsp (2.5 ml)
	18-23 lbs.	12-23 mo.	1.875 ml (1.25+0.025)	-	3/4 tsp (3.75 ml)
	24-35 lbs.	2-3 yrs.	2.5 ml (1.25+1.25)	-	1 tsp (5 ml)
	36-47 lbs.	4-5 yrs.	3.75 ml (1.25+1.25+1.25)	-	1 ½ tsp (7.5 ml)
	48-59 lbs.	6-8 yrs.	5 ml (1.25+1.25+1.25+1.25)	-	2 tsp (10 ml)

Child's Name:	Kinderberry Hill Location:
Child's Age	Physician's Signature:
Date:	Parent's Signature: