COVID-19
Free Child Care at LifeStyleRx for Children of Stanford Health Care, Stanford Health Care - ValleyCare, and Stanford Affiliate Employees

We are happy to share with Stanford Health Care (SHC), Stanford Health Care – ValleyCare (SHC – VC), and Stanford Affiliate employees that LifeStyleRx, located in Livermore, is available to support you and your family with child care service. During this health emergency, the child care service is offered at no charge.

This free service will be available to your dependent children between the ages of 5 and 14 while you are on shift at SHC, SHC – VC, or Stanford Affiliate locations, Monday through Friday, from 6:00 a.m. - 8:00 p.m. We will keep your children entertained with arts and crafts, board games, air hockey, basketball, and much more!

To take advantage of this free service you will need to:

1. Make a reservation 24 hours in advance, preferably. Please send an email to EmployeeDaycare@stanfordhealthcare.org
2. Complete a Registration Packet for your child/ren (medical history, emergency contacts, etc.), available at check-in on your first day, or on the intranet here.
3. Provide snacks and meals for your child/ren according to the length of stay.
4. Provide downtime blankets and a small pillow as appropriate.
5. Provide driver's license identification at child/ren pick up.

We recommend that children bring their laptops for school work.

LifeStyleRx is located at 1119 E. Stanley Blvd., Livermore, CA 94550. (925) 454-6342

We look forward to caring for your children while you care for our patients during these challenging times. Thank you for all you do!

For more information, please contact Sam Reid at sreid@stanfordhealthcare.org

Stanford HEALTH CARE
STANFORD MEDICINE

ValleyCare

March 26, 2020

EMPLOYEE

Child Name_____ Completion Date _____

Employee Name _____ Phone #_____

Department _____ Supervisors Name _____

LifeStyleRx DAY CARE PARENT INFORMATION PACKET

Welcome! We are pleased to offer child care during this health emergency while you are on shift at Stanford Health Care -ValleyCare. Your child will enjoy all child care amenities under supervision of our excellent child care staff.

Our focus at LifeStyleRx Child Care is to provide your child with an enjoyable and safe experience. We have various toys and activities to accommodate all age groups, so your child can learn, play and grow.

If you have any questions or concerns regarding this packet, please contact us at 925-454-6342

Child Care Hours

Monday- Friday 6.30am-7:30pm

Please bring food for your child for the duration of their stay. We will have set snack and meal times, and all food will be consumed in the designated café area. Please inform staff of any allergies. There is no food allowed in the actual child care area, only drinks permitted are water or milk baby bottles. Clearly label all lunches and food. Please no peanuts and other common allergens. Please bring blankets for nap time.

To drop off your child please present your badge and complete the drop off register. The following packet has the Emergency Medical Authorization, Health History form and the Sick Child Policy, and authorization for who can drop off and pick up your child. Please read and complete all required sections and submit before your first drop off in child care. **Child Care Main Rules**

1. Food must be kept and consumed in the café area.
2. Only water in no spill cups and baby bottle milk are permitted outside of the café area.
3. Gum is prohibited
4. Outside toys / electronics are prohibited in child care. Books are allowed.
5. Jewelry / accessories that could present a hazard are prohibited - example beaded necklace. Comfort blankets are allowed.

Infants

1. Please put a name tag on diaper bags
2. All bottles must be prepared and labeled
3. Please label diapers.
4. Please label pacifiers.

Please bring blankets / pillows for down time.

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EMPLOYEE CHILD'S HEALTH HISTORY-PARENT'S REPORT

PLEASE PRINT

Child Name _____ _____ ____ Date_____
Last Name First Name M.I.

Address _____
Street Address City State Zip

Home Phone _____ Gender □ M □ F Age _____ Birth Date_____

Parents / Guardians Name_____

Parents/Guardians Address _____

Parents / Guardians Phone_____ Work Phone_____
_

If neither parent can be reached by phone in case of emergency, please call the following contact:

Name _____ Relation_____

Phone _____ Secondary Phone _____

Physician _____ Phone_____

Dentist _____ Phone_____

Other Instructions (hospital preference,etc.)_____

ALLERGIES please supply EPI pen if appropriate. **EPI PEN Y / N**

MEDICAL HISTORY

1. Has your child ever been hospitalized?	Yes	No
2. Has your child ever had surgery?	Yes	No
3. Has your child ever been dizzy or fainted during or after exercise?	Yes	No
4. Has your child ever been told that they have a heart murmur?	Yes	No
5. Does your child have any skin problems (itching, rashes, acne)?	Yes	No
6. Has your child ever been knocked out, unconscious, or suffered a head injury?	Yes	No
7. Has your child ever had a seizure?	Yes	No
8. Has your child had a burn, stinger, or pinched nerve?	Yes	No
9. Has your child ever had heat/muscle cramps, been dizzy or passed out in the heat?	Yes	No
10. Does your child have trouble breathing or cough during/after exercise?	Yes	No
11. Does your child use any special equipment (i.e., pads, braces, eye guard, etc.)?	Yes	No
12. Has your child had any problems with their eyes or vision?	Yes	No
13. Does your child wear glasses, contacts or protective eyewear?	Yes	No

(Continued on reverse side)

14. Has your child ever sprained/strained, dislocated, fractured, broken or had repeat swelling of any of bones and/or joints? If yes, please list below. Yes No
15. Has your child ever had any other medical problem (infection, mononucleosis, diabetes)? Yes No
16. Is your child presently taking any medications? If yes, list below. Yes No
17. Does your child have any allergies? If yes, list below. Yes No
18. does your child have learning disabilities / developmental delay? Yes No

If you circled yes to any of the questions above, please explain below:

_____
_____
_____
_____
_____
_____
_____
____

PAST ILLNESSES- Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
□ Chicken Pox	_____	□ Diabetes	_____	□ Poliomyelitis	_____
□ Asthma	_____	□ Epilepsy	_____	□ Ten-Day Measles (Rubeola)	_____
□ Rheumatic Fever	_____	□ Whooping Cough	_____	□ Three-Day Measles (Rubella)	_____
□ Hay Fever	_____	□ Mumps	_____		

Sick children

We will not accept any child if he/she has any of the following visual symptoms, including but not limited to: runny nose cough, fever, conjunctivitis, flu, rash, severe cough, rapid / labored breathing, cold, vomiting, diarrhea, yellowish skin or eyes, head lice, sore throat, in pain, contagious disease.

We will not accept the child for care if any of the above symptoms are present or have been present within the last 14 days. If the child shows any of the symptoms while in care, we will remove him from the group and notify the parent or authorized adult to pick up the child. A Doctor's note may be required to return to child care.

By signing this questionnaire for your child, you agree to notify LifeStyleRx Management if there is a change in your child's health status

Parents / Guardian Signature _____Date _____

ADDITIONAL INFORMATION

If your child has allergies, please tell us their allergens, symptoms, and how to manage a reaction:

1. Allergen _____ Symptoms _____

   Treatment
   _____

2. Allergen _____ Symptoms _____

   Treatment
   _____

3. Allergen _____ Symptoms _____

   Treatment
   _____

If your child has any behavioral or developmental delays, please elaborate and explain how we can best help your child:

_____
_____
_____
_____
_____

If your child has any dietary restrictions, we should be aware of, please elaborate:

_____
_____
_____
_____
_____

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MEDICATION AUTHORIZATION AND CONSENT FORM

Child's Name _____ Age _____

Parent/Guardian Name _____ DOB _____

To be completed by health care provider:

- Medication _____ Exact Dosage/Route _____

  Time(s) _____ Additional Info _____

  For any **as needed** medications, please list symptoms to indicate a dosage is required:

  _____

- Medication _____ Exact Dosage/Route _____

  Time(s) _____ Additional Info _____

  For any **as needed** medications, please list symptoms to indicate a dosage is required:

  _____

- Medication _____ Exact Dosage/Route _____

  Time(s) _____ Additional Info _____

  For any **as needed** medications, please list symptoms to indicate a dosage is required:

  _____

Provider Signature _____ Physician Office Stamp

Date _____

To be completed by parent/guardian:

- I authorize Lifestyle Rx Stanford Health Care ValleyCare personnel to assist with the above medication for my child according to physician instruction. I understand that trained, non-medical personnel may assist with this medication.
- This form must be renewed whenever prescription changes.
- I understand that it is my responsibility to bring medication to Lifestyle Rx Stanford Health Care ValleyCare in pharmacy labeled containers and that medications must not be expired. All medications and supplies must have child's name clearly marked.
- All over the counter medications must be included in the prescription.
- I understand that by signing below I agree to release from liability Lifestyle Rx Stanford Health Care ValleyCare employees and agents for any loss, damage, injury, or liability of any kind to any person caused or arising from the acts, omissions or negligence of Lifestyle Rx Stanford Health Care ValleyCare employees and agents related to the assistance of medication to my child.
- I authorize Lifestyle Rx Stanford Health Care ValleyCare personnel to communicate with my child's health care provider for clarification purposes
- I have read and understand the letter attached to this consent form

Parent/Guardian Signature _____ Date _____

Cell Phone # _____ Work Phone # _____

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CHILD RELEASE ON GOING AUTHORIZATION

Date _____

Parent / Guardian Name_____

Phone Number _____

Child Name _____ Age_____ M/F_____

Child Name _____ Age_____ M/F_____

Adult authorized to pick up /drop off above named child _____

Authorized Adult Phone Number_____

Adult authorized to pick up /drop off above named child _____

Authorized Adult Phone Number_____

Adult authorized to pick up /drop off above named child _____

Authorized Adult Phone Number

I hereby authorize LifeStyleRx to release the above-named child(s) to the named authorized adult(s) above. This will be effective until further written instruction is submitted to LSRX. It is your responsibility to notify LSRX of any change to this authorization.

Assumption of Risk, Liability & Indemnity - Guest hereby acknowledges and agrees that the use of LifeStyleRx facility and Services involves the risk of property loss, substantial personal injury or even death.

GUEST RELEASES ANY AND ALL RESPONSIBILITY FOR PERSONAL INJURIES AND/OR PROPERTY LOSS/DAMAGE SUSTAINED BY ANY MEMBER OR ANY GUEST OF ANY MEMBER WHILE ON THE PREMISE, WHETHER USING EXERCISE EQUIPMENT OR NOT.

Guest assumes and accepts, on behalf of himself/herself and any minor child guest/member, the risk of injury and damage inherent in the use of LifeStyleRx facility and Services and hereby fully releases LifeStyleRx in consideration for use of the facility all and any damage claims arising out of LifeStyleRx's own negligence.

The undersigned hereby releases LifeStyleRx, Stanford Health Care ValleyCare, its shareholders, directors, officers, contractors, agents, volunteers, and affiliated entities from any and all liability and/or responsibility to member or any third party for any direct, indirect, punitive, incidental, or any damages whatsoever that arise out of or are related to member's use of the LifeStyleRx facility and Services or the negligence or other acts of LifeStyleRx members or guests using the facility and Services.

Additionally, guest shall indemnify, defend and hold LifeStyleRx, Stanford Health Care ValleyCare harmless against any and all claims for injury or damages asserted by any third party arising out of or relating to the conduct of guest, guest's family members or member's guests.

Arbitration - Any dispute, claim or controversy that arises out of or relates to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope of applicability of this Agreement to arbitrate, shall be determined by arbitration in Pleasanton, CA, before a sole arbitrator, in accordance with the laws of the State of California for agreements made in and to be performed in that State. The arbitration shall be administered by JAMS pursuant to its Streamlined Arbitration Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. The arbitrator shall, in the award, allocate all of the costs of arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party, against the party who did not prevail.

Parent / Guardian Signature _____ Date _____

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EMERGENCY MEDICAL AUTHORIZATION

I/we, the undersigned, am/are the parent / guardian of _____, minor(s).

CONSENT

I/we hereby give consent, in the event I/\we cannot be contacted within a reasonable time, for (1) the administration of any treatment deemed necessary for my/our children by Dr._____, or any of his her associates, the preferred physician, or Dr. _____, or any of his/her associates, the preferred dentist, or in the event the appropriated preferred practitioner is not available, by another licensed, qualified physician or dentist; and (2) the transfer of any of my/our children to _____ Hospital, the preferred hospital, or any hospital reasonable accessible.

MAJOR SURGERY

This authorization does not cover non-emergency major surgery unless the medical opinion of two other licensed physicians or dentist concurring in the necessity for such surgery are obtained prior to the performance of such surgery and unless all reasonable attempts to contact me/us have been unsuccessful, defining such period for non-emergency surgery as 24 hours.

MEDICAL DATA

The following is needed by any hospital or practitioner not having access to my/ our children's medical history:

Allergies: _____

Medication being taken: _____

Physical Impairments: _____

Developmental Delays / Learning Disabilities _____

Other pertinent facts to which physician should be alerted: _____

_____

Medical Insurance Company: _____

Medical Group Number: _____ Medical Id Number: _____

I/we, the undersigned parent(s) also do by these premises appoint and constitute LifeStyleRx employees as temporary custodians of my/our children and do hereby authorize them to obtain and x-ray examination, anesthesia, medical or surgical diagnosis or treatment, and hospital care to be rendered to my/our children in our absence, under the general or special supervision, and on the advice of, a licensed physical, surgeon, anesthesiologist, dentist, or other qualified personnel acting under their supervision.

Parent / Guardian Signature _____

Date _____

Expires_____