

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent..
- The child’s health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state “consult a physician”; the parent completes #19 through #23.

1. Child’s first and last name: Alan Barth		2. Date of birth: 1/30/01		3. Child’s known allergies: None	
4. Name of medication (including strength): Children’s Strength Liquid Tylenol			5. Amount/dosage to be given: One teaspoon		6. Route of administration: Oral
7A. Frequency to be administered: _____ <p style="text-align: center;"><i>OR</i></p> 7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) give as needed if temperature is over 101°F. May repeat dose once every four hours. Do not give more than 4 times in a 24 hour period.					
8A. Possible side effects: <input checked="" type="checkbox"/> Parent must supply package insert or pharmacy printout for complete list of possible side effects see medication box AND/OR					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input checked="" type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____					
10A. Special instructions: <input checked="" type="checkbox"/> Parent must supply package insert or pharmacy printout for complete list of possible side effects medication box AND/OR					
10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child’s age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____					
11. Reason the child is taking the medication (unless confidential by law): to manage febrile seizures					
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete #33-#34 on the back of this form.					
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #35-#36 on the back of this form.					
14. Date consent form completed: 1/20/05			15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid): 3/1/05		
16. Prescriber’s name (please print): Nancy Wallace, MD			17. Prescriber’s telephone number: (914) 564-9832		
18. Licensed authorized prescriber’s signature: <i>Nancy Wallace, MD</i> Required for Long-Term medications or when dosage directions state “consult a physician”.					

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm): _____	
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to <u>Alan Barth</u> <small>(child's name)</small>	
21. Parent or legal guardian's name (please print): Diane Barth	22. Date authorized: January 22, 2005
23. Parent or legal guardian's signature: <i>Diane Barth</i>	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name: ABC Child Care	25. Facility telephone number: (914) 555-2784	26. (leave blank)
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
28. Authorized child care provider's name (please print): Ronald Murphy	29. Date received from parent: 1/22/05	
30. Authorized child care provider's signature: <i>Ronald Murphy</i>		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ . Once the medication has been discontinued, I understand that if my child <small>(date)</small> requires this medication in the future, a new written medication consent form must be completed.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. <u>see individual health care plan on file at the child day program</u>
34. Licensed Authorized Prescriber's Signature: <i>Nancy Wallace, MD</i>
35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE: _____ By completing this section the child day program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature: