

## **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. <u>Multiple medications cannot be listed on one consent form.</u>
- 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:	2. Da	te of birth:	3. Child's kr	own allergies:			
4. Name of medication (including strength)	<u> </u>	5. Amount/dosage	5. Amount/dosage to be given: 6. Route of adm				
7A. Frequency to be administered:							
OR  7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters)							
0.4 D 111 11 00 4 -							
8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects  AND/OR							
8B: Additional side effects:							
9. What action should the child care provider take if side effects are noted:  □ Contact parent □ Contact prescriber at phone number provided below  □ Other (describe):							
10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions							
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):							
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?  □ No □ 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?  □ No □ Yes If you checked yes, complete #35-#36 on the back of this form.							
		Date to be discontinued or length of time in days to be given (this date not exceed 6 months from the date authorized or this order will not be valid):					
16. Prescriber's name (please print):		17. Prescriber's	17. Prescriber's telephone number:				
18. Licensed authorized prescriber's signature: Required for Long-Term medication or when dosage directions state "consult a physician".							



## Written Medication Consent Form PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

THREE 17 GUILLE IN THE ST CONT.						
19. If Section #7A is completed, do the instructi (For example, did the prescriber write 12pm?) Write the specific time(s) the child day program	$\Box Yes  \Box \ N/A$	□ No				
20. I, parent/legal guardian, authorize the child of "Licensed Authorized Prescriber Section" to			ation as specified in the			
		(child's name)				
21. Parent or legal guardian's name (please prin	22. Date authorized:					
23. Parent or legal guardian's signature:						
CHILD DAY PROGRAM TO COMPI	LETE THIS	SECTION (#24 -	#30)			
24. Provider/Facility name:	25. Facility telephone number:		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 (plea	se print):	29. Date received from parent:				
30. Authorized child care provider's signature:						
ONLY COMPLETE THIS SECTION DISCONTINUE THE MEDICATION  31. I, parent/legal guardian, request that the medical statement of the second s	PRIOR TO	THE DATE IND	ICATED IN #15			
Once the						
Conce the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.						
32. Parent or Legal Guardian's Signature:						
LICENSED AUTHORIZED PRESCR	IBER TO C	OMPLETE, AS N	<b>NEEDED</b> (#33 - #36)			
33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child.						
34. Licensed Authorized Prescriber's Signature:						
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:						