

BAREFOOT KIDS CHRISTIAN DAY SCHOOL

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-#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 MUST ALSO COMPLETE #19-#23.**

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:	
4A. Name of Medication:	4B. Strength	5. Amount/Dosage to be Given:	6. Route of Administration:

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)

8A. Possible side effects: _____ Parent must supply package insert (or pharmacy printout) for a 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. Specific 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.

14. Date consent form completed:

____/____/____

15. Date to be discontinued or length of time in days to be given (date cannot exceed 6 months from the date authorized or this order will not be valid:

____/____/____

16. Prescriber's Name (please print):

17. Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

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?) ____ Yes ____ N/A ____ 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 (CHILD'S NAME) _____

21. Parent or legal guardian's name (PLEASE PRINT):	22. Date Authorized: _____/_____/_____
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23. Parent or legal guardian's signature:

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

24. Provider / Facility Name: BAREFOOT KIDS CHRISTIAN DAY SCHOOL	25. Facility telephone number: 757-467-1234 / (f) 757-467-5285	26. (leave blank)
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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 Barefoot Kids Christian Day School.

28. Authorized Child Care Provider's Name - Must be MAT Certified (please print):	29. Date received from parent: _____/_____/_____
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30. Authorized child care provider's signature - must be MAT Certified:

ONLY COMPLETE THIS SECTION IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN SECTION #5

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on (DATE) _____. Once 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 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.

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 not follow the pharmacy label until the new prescription has been filled.

34. Licensed Authorized Prescriber's Signature:

