

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." Parents completes #19 through #23.

1. Child's first and last name:	2. Date of Birth	3. Child's known allergies:
4. Name of Medication (including 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 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: <input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> 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 the child generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #33-34 on the back of this form		
13. Are the instruction 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 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:	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):	
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 12 pm?) <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the program is to administer the medication: _____	
20. I, parent/legal guardian, authorize the 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: _____
23. Parent or legal guardian's signature: _____	

Child Care Program to Complete This Section (#24 - #30)

24. Provider/Facility Name: Centerville Baptist Pre-School	25. Facility telephone number 757.482.4466	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 care program.		
28. Authorized child care provider's name (please print) Cathy Curling, Director OR Suzanne Miller, Asst. Director	29. Date received from parent: _____	
30. Authorized child care provider's signature: _____		

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 (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/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 update the 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.
36. Licensed Authorized Prescriber's Signature: _____