

WRITTEN MEDICATION CONSENT FORM

All Saints Catholic School

- 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: _____
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:

___ 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 possible side effects

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 require 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 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 (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 medication or when dosage directions state, "consult a physician."

This is a double-sided form.

Written Medication Consent Form

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: _____
23. Parent or legal guardian's signature: _____

Child Day Program To Complete This Section (#24-#30)

24. Provider/Facility Name: All Saints Catholic School
25. Facility telephone number: 804-329-7524
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): _____
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 to be discontinued on _____ . 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 doze, 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.

36. Licensed Authorized Prescriber's Signature: _____

MEDICATION LOG FORM

Child's Name and Grade _____

DATE (M/D/Y)	TIME (am or pm)	DOSE	MEDICATION	COMMENTS (ERRORS, REACTIONS)	GIVEN BY (Full Signature and Print Name)