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.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for a	ver-the-coi	inter topical ointments, s						
1. Child's first and last name:	2. Da	2. Date of birth: 3. Child's known all		own allergies:				
4. Name of medication (including strengtl):	5. Amount/dosage	to be given:	6. Route of administration:				
A & D Ointment	,	Apply liberally to d	_	Topical				
7A. Frequency to be administered: —								
OR								
7B. Identify the symptoms that will ne								
observable and, when possible, measurable parameters) Chafed skin or minor skin irritation due to diaper rash.								
8A. Possible side effects: See package insert for complete list of possible side effects (parent must supply)								
ori. I ossible side effects.	50 1115011 1	$\frac{OOMPICEC}{AND/OR}$	ossioie side ei	parent must suppry)				
8B: Additional side effects: Condition worsens								
COMMINION WOLDERS								
9. What action should the child care provider take if side effects are noted:								
x Contact parent		Contact prescribe	er at phone nur	mber provided below				
□ Other (describe):								
10 A Special instructionar - Secondary	incont (Com a amendata list of se	a a si a1 in atms ati	2002 (11 2014 11 11 11 11 11 11 11 11 11 11 11 11 1				
10A. Special instructions: \square See package insert for complete list of special instructions (parent must supply) AND/OR								
10B. Additional special instructions: (I	aaluda anv		ossible interacti	one with other medication the				
child is receiving or concerns regarding th								
existing conditions. Also describe situation								
Stop use if condition worsens or does not improve within 7 days.								
11. Reason the child is taking the medi	cation (un	less confidential by la	w): Diaper ra	sh				
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 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?								
x No □ Yes If you checked yes, complete #35-#36 on the back of this form.								
14. Date prescriber authorized:	14. Date prescriber authorized: 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 nur	nber:				
(please plint).			po.iv iidi					
18. Licensed authorized prescriber's signature:								

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 day care program is to administer the medication (i.e.: 12pm): ————								
20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to								
21. Parent or legal guardian's name		22. Date authorized:						
23. Parent or legal guardian's signature:								
DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)								
24. Provider/Facility name: Corning Children's Center	25. Facility ID number: 42396DCC	26. Facility telephone number: 937-5502						
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 day care program.								
28. Authorized child care provider's name (please print):		29. Date received from parent:						
30. Authorized child care provider's	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								
. Once the medication has been discontinued, I understand that if my child								
requires this medication in the futur		n consent form must be completed.						
32. Parent or Legal Guardian's Sign	nature:							
		OMPLETE, AS NEEDED (#33 - #36)						
33. Describe any additional training, procedures or competencies the day care 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 day care 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:								

Written Medication Consent Form							