

ECFC WRITTEN MEDICATION CONSENT FORM



One form must be completed for each medication.
Multiple medications **can not** be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER must complete #1 - #16
See section #29 - #34 on back for chronic conditions or changes to previous medication orders

1. Child's first and last name: Jane Doe	2. Date of birth: 1/1/07	3. Child's known allergies: None
4. Name of medication (including strength): Child Acetaminophen	5. Amount/dosage to be given: 1/2 Tsp	6. Route of administration: Oral
7A. Frequency to be administered (i.e. 3-X Daily, every 4-6 hours, etc.): Every 4-6 hours after initial dose		
AND FOR SYMPTOMATIC MEDICATION: 7B. Identify the symptoms that will necessitate administration of medication; Signs and symptoms must be observable and, when possible, measurable parameters. (i.e. fever greater than 100°) Fever above 101		
8. Date to be discontinued or length of time in days to be given (Maximum of 6 months from the date authorized): 12/31/08		
9A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects (parent must supply) AND/OR		
9B. Additional side effects: <input type="checkbox"/>		
10. What action should the child care provider take if side effects are noted (check all that apply): <input checked="" type="checkbox"/> Contact parent (ECFC Policy) <input type="checkbox"/> Contact prescriber at number provided below <input type="checkbox"/> Other (describe): <input type="checkbox"/>		
11A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions (parent must supply) AND/OR		
11B. 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 any situations when medication should not be administered): <input type="checkbox"/>		
12. Reason the child is taking the medication (unless confidential by law): Fever		
13. Prescriber's name (please print): Dr Jones	14. Prescriber's telephone number: 555-1212	
15. Licensed authorized prescriber's signature: X	16. Date authorized: 6/30/08	

PARENT/GUARDIAN must complete #17 - #20

17. I, John Doe (please print), parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to the above named child.	
18. Parent or legal guardian's signature: X	19. Date authorized: 7/1/08
20. Fill out #20 ONLY for medication that requires administration at a specified frequency and thus at a specific time. (i.e. Prescribed for 3 times daily): Please write the specific time(s) the day care program is to administer the medication: <input type="checkbox"/>	

Symptomatic Medication: Common Errors & Watch Outs

- The rear side of the form rarely needs input from either the physician or the parent
- All Medication must be in its original package with the label intact
- Dosage device must have marking for dose indicated – ECFC cannot ‘estimate’ between lines on cup or dropper
- Ensure that the medication strength is noted (child versus infant versus adult)
- If the prescriber writes “Tylenol” you must deliver Tylenol – not store brand Acetaminophen, If Acetaminophen is written you must deliver store brand & not Tylenol. One way to avoid issues is to have the prescriber write Tylenol/Acetaminophen
- Symptoms must be clearly identifiable
- Maximum length of authorization is 6 months
- If checked you must deliver the package insert – if not checked you must fill in any required instructions

ECFC WRITTEN MEDICATION CONSENT FORM



One form must be completed for each medication.
Multiple medications **can not** be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER must complete #1 - #16

See sections #19 - #24 on back for chronic conditions or changes to previous medication orders

1. Child's first and last name: Jane Doe	2. Date of birth: 1/1/07	3. Child's known allergies: None
4. Name of medication (including strength): Augmentin 125/5ml	5. Amount/dosage to be given: 1 Tsp	6. Route of administration: Oral
7A. Frequency to be administered (i.e. 3-X Daily, every 4-6 hours, etc.): 3x Daily AND FOR SYMPTOMATIC MEDICATION:		
7B. Identify the symptoms that will necessitate administration of medication: Signs and symptoms must be observable and, when possible, measurable parameters. (i.e. fever greater than 100) [Redacted]		
8. Date to be discontinued or length of time in days to be given (Maximum of 6 months from the date authorized): 10 days		
9A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects (parent must supply) AND/OR		
9B. Additional side effects: [Redacted]		
10. What action should the child care provider take if side effects are noted (check all that apply): <input checked="" type="checkbox"/> Contact parent (ECFC Policy) <input type="checkbox"/> Contact prescriber at number provided below <input type="checkbox"/> Other (describe): [Redacted]		
11A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions (parent must supply) AND/OR		
11B. 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 any situations when medication should not be administered): [Redacted]		
12. Reason the child is taking the medication (unless confidential by law): Ear Infection		
13. Prescriber's name (please print): Dr Jones	14. Prescriber's telephone number: 555-1212	
15. Licensed authorized prescriber's signature: X	16. Date authorized: 6/30/08	

PARENT/GUARDIAN must complete #17 - #20

17. I, John Doe (please print), parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to the above named child.	
18. Parent or legal guardian's signature: X	19. Date authorized: 7/1/08
20. Fill out #20 ONLY for medication that requires administration at a specified frequency and thus at a specific time. (i.e. Prescribed for 3 times daily): Please write the specific time(s) the day care program is to administer the medication: Noon	

Fixed Frequency Medication: Common Errors & Watch Outs

- The rear side of the form rarely needs input from either the physician or the parent
- All Medication must be in its original package with the label intact
- Dosage device must have marking for dose indicated – ECFC cannot 'estimate' between lines on cup or dropper
- If checked you must deliver the package insert – if not checked you must fill in any required instructions