



Dear Parent,

If your child has a known allergy and will require emergency medication to be maintained at Living Savior Preschool, a **Written Medication Consent Form** for each medication is mandatory.

This form must be completed in full and signed by your child's physician and the parent or legal guardian and submitted along with the emergency medication/s **before** your child may begin school. The **Written Medication Consent Form** must be turned in with all medications and administration tools. **This must be done before your child's open house date. Please call the preschool office to make an appointment to go over your child's Written Medication Consent Form(s) and Medication(s) with office personnel.**

Administration Tools and Medication Label Requirements

1. Medications must have a current expiration date and be in their **original packaging and labeled with the child's first and last name.**
2. Administration tools such as dosing spoons, medicine cups, oral medication syringes, etc. must be provided by the parents. All administration tools must be **labeled with the child's first and last name.**
3. Parents are **required** to provide a new prescription and before the expiration date if medication expires during the school year.
4. Prescription medication should be in its **original packaging** with the **original pharmacy label** that includes the following items:
 - Child's First and Last name
 - Authorized prescriber's name
 - Pharmacy name and telephone
 - Date prescription was filled
 - Name of the medication
 - Route of administration
 - Dosage of the medication
 - How often to give the medication
 - Expiration Date

Thank you in advance for completing this form/s before for your child's open house date.



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." 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: <input type="checkbox"/> 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: <input type="checkbox"/> 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?					
<input type="checkbox"/> No <input type="checkbox"/> 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?					
<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 12 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:

25. Facility telephone number:

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 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.

36. Licensed Authorized Prescriber's Signature: