NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM **CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER	COM	PLETE THIS SECTION	ON (#1 - #18)	AND AS NEEDED (#33 - 35).		
1. Child's First and Last Name:	2. Dat	te of Birth:	3. Child's Known Allergies:			
4. Name of Medication (including strength):		5. Amount/Dosage to be	e 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: See package ins	ert for co	emplete list of possible sid	de effects (parent	must supply)		
AND/OR						
8B: Additional side effects:						
9. What action should the child care provider take	f side ef	fects are noted:				
☐ Contact parent ☐ Contact	t health	care provider at phone n	umber provided b	pelow		
Other (describe):						
10A. Special instructions:	rt for cor	mplete list of special instru	uctions (parent m	ust supply)		
AND/OR						
10B. Additional special instructions: (Include any c concerns regarding the use of the medication as it						
situation's when medication should not be adminis	tered.) _					
11. Reason for 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?						
☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.						
13. Are the instructions on this consent form a charmedication is to be administered?	nge in a	previous medication orde	er as it relates to t	the dose, time or frequency the		
☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.						
14. Date Health Care Provider Authorized: 15. I	Date to b	e Discontinued or Length	of Time in Days	to be Given:		
16. Licensed Authorized Prescriber's Name (pleas	e print):	17. Licensed A	Authorized Presci	riber's Telephone Number:		
18. Licensed Authorized Prescriber's Signature:						
X						

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PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instraction authorized prescriber write 12pm?)	•	ime to	administer t	he medication? (For example, did the licensed		
Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm):						
20. I, parent, authorize the day care program	m to administer the medicati	ion, as	specified or	n the front of this form, to (child's name):		
21. Parent's Name (please print):	2	22. Date Authorized:				
23. Parent's Signature:						
CHILD DAY CARE PROGRAM CO	MPLETE THIS SECTION	ON (#24 - #30)			
24. Program Name:	25. Facility ID Number:	`	,	26. Program Telephone Number:		
27. I have verified that (#1 - #23) and if app this medication has been given to the day c		olete. N	/ly signature	indicates that all information needed to give		
28. Staff's Name (please print):			29. Date R	. Date Received from Parent:		
30. Staff Signature:						
х						
ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)						
31. I, parent, request that the medication in	dicated on this consent form	n be dis	scontinued o			
	d 1 d t d th - t 'f h '			(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 Signature:						
LICENSED AUTHORIZED PRESC	RIBER TO COMPLETI	E, AS	NEEDEI	 D (#33 - #35)		
33. Describe any additional training, proced						
34. Since there may be instances where the frequency until the medication from the prevente administration of the prescription to take DATE:	vious prescription is complet	v preso tely us	cription for cl ed, please in	hanges in a prescription related to dose, time or ndicate the date you are ordering the change in		
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.						
35. Licensed Authorized Prescriber's Signa X	iture.					
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NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

 ☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying
 □ Other (specify) □ Shortness of breath, wheezing, or coughing □ Pale or bluish skin, faintness, weak pulse, dizziness □ Tight or hoarse throat, trouble breathing or swallowing □ Significant swelling of the tongue or lips □ Many hives over the body, widespread redness □ Vomiting, diarrhea □ Behavioral changes and inconsolable crying □ Other (specify) □ Shortness of breath, wheezing, or coughing □ Pale or bluish skin, faintness, weak pulse, dizziness □ Tight or hoarse throat, trouble breathing or swallowing □ Significant swelling of the tongue or lips □ Many hives over the body, widespread redness □ Vomiting, diarrhea □ Behavioral changes and inconsolable crying □ Other (specify)

OCFS-6029 (12/2020)		
Date of Plan:	/	1

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- Inject epinephrine immediately and note the time when the first dose is given.
- Call 911/local rescue squad (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up
 or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

*Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area. Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:				
EMERGENCY CONTACTS – CALL 911				
Ambulance: () -				
Child's Health Care Provider:	Phone #: ()	-	
Parent/Guardian:	Phone #: ()	-	
CHILD'S EMERGENCY CONTACTS	·			
Name/Relationship:	Phone#: ()	-	
Name/Relationship:	Phone#: ()	-	
Name/Relationship:	Phone#: ()	-	
Parent/Guardian Authorization Signature:	Date:	/	1	
Physician/HCP Authorization Signature:	Date:	/	1	
Program Authorization Signature:	Date:		1	