Written Medical 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 #24 (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 provide MUST complete #1 through #18 for Long-Term medication or when dosage directions state "consult a physician"; the parent completes #19 through #23

WDS does not administer the initial dosage of a medication, except with physician's written permission for life-threatening situations.

1. Child's Full 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, measureable parameters): ____

8A. Possible side effects: Parents must supply package insert (or pharmacy print out) for a complete list of possible side effects
AND/OR
8B. Additional side effects:
____

9. What action should the child care provide take if side effects are noted: (Please circle the appropriate answer)
Contact Parent
Contact prescriber at phone number provided below
Other (describe): ____

10A. Special instructions: Parents 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 children 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 be me administer: ________________________
____

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? (Please circle the appropriate answer).

Yes No

If you circled 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 related to the dose, time or frequency the medication is to be administered?

Yes No

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 (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 Medications or when dosage directions state "consult a physician":

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (Please Circle)

Yes No

Write the specific time(s0 the child day program is to administer the medication (i.e. 12 pm): _____________

20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to ___________________________________

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: **Westhampton Day School**	25. Facility telephone number: **(804) 282-7459**	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 INDICATE IN #15

31. I, parent/legal guardian, request that the medication indicate on this consent form be discontinued on _______________. Once the medication has been discontinued. I understand that if my child requires this medication in
(date)
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:

WDS Staff Only: I have read the label on the medication, and can verify that parental instructions are consistent with the label. Please Initial: ___________