

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 COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication (<i>including strength</i>):	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: (<i>signs and symptoms must be observable and, when possible, measurable parameters</i>): _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (<i>parent must supply</i>)		
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 health care provider at phone number provided below		
<input type="checkbox"/> Other (<i>describe</i>): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (<i>parent must supply</i>)		
AND/OR		
10B. Additional special instructions: (<i>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 situation's when medication should not be administered.</i>) _____		
11. Reason for medication (<i>unless confidential by law</i>): _____		
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 and #35) 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 (#34 -#35) on the back of this form.		
14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /	
16. Licensed Authorized Prescriber's Name (please print):		17. Licensed Authorized Prescriber'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 instructions indicate a specific time to administer the medication? <i>(For example, did the licensed authorized prescriber write 12pm?)</i> <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the child day care program is to administer the medication <i>(i.e.: 12 pm)</i> : _____	
20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to <i>(child's name)</i> :	
21. Parent's Name <i>(please print)</i> :	22. Date Authorized: / /
23. Parent's Signature: X	

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:
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. Staff's Name <i>(please print)</i> :	29. Date Received from Parent: / /	
30. Staff Signature: X		

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 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 Signature: X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
34. 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 you are ordering the change in the administration of the prescription to take place. 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.
35. Licensed Authorized Prescriber's Signature: X

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CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /
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Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). Yes No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	5 th Date / /
Polio (IPV or OPV)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date OR 1 st Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Hepatitis B	1 st Date / /	2 nd Date / /	3 rd Date / /		
Measles, Mumps and Rubella (MMR)	1 st Date / /	2 nd Date / /			
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: Positive Negative _____ mm
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /
 Attach lead level statement
Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL Venous Capillary
 2 years / / Result: _____ mcg/dL Venous Capillary

Most recent date of lead screening (if different from above):
 / / Result: _____ mcg/dL Venous Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.
 If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

