

## WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which Cozy DayCare is literal.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

### LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

*(Parents may complete #1-#17 (skip #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)*

1. Child's first and last name:	2. Date of births:	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: _____		
<b>OR</b>		
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"/> See package insert for complete list of possible side effects (parent must provide)		
<b>AND / OR</b>		
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. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (parent must provide)		
<b>AND / OR</b>		
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 to last 12 months or more and require 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 check YES, complete #35 - #36 on page 2.		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition to last 12 months or more and require 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 check YES, complete #35 - #36 on page 2.		
14. Date Prescriber authorized:	15. Date to be discontinued or length of time in days to be given (this 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:  <b>X</b>		

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## 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) Cozy DayCare is to administer the medication (i.e. 12pm): \_\_\_\_\_

20. I, parent/legal guardian, authorize Cozy DayCare to administer the medication as specified in the "Licensed Authorized Prescriber Section" Write the to \_\_\_\_\_

(child's name)

21. Parent or legal guardian's name (please print): \_\_\_\_\_

22. Date authorized: \_\_\_\_\_

23. Parent or legal guardian's signature:

X

## COZY DAYCARE TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility Name: \_\_\_\_\_

25. Facility ID number: \_\_\_\_\_

26. Facility 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 Cozy DayCare.

28. Authorized child care provider's name (please print): \_\_\_\_\_

29. Date received from parent/guardian: \_\_\_\_\_

30. Authorized child care provider's signature:

X

## ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form to 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:

X

## LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies Cozy DayCare staff will need to care for this child.

\_\_\_\_\_  
\_\_\_\_\_

34. Licensed Authorized Prescriber's signature:

X

35. Since there may be instance 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 Cozy DayCare will follow the written instruction on this form and **not** follow the pharmacy label until the new prescription has been filled.

34. Licensed Authorized Prescriber's signature:

X