Written Medication Consent Form

Child's Name (First and Last):_____ **Date of Birth**:_____ **Known Allergies:**_____

Provider Name: Rich Beginnings Child Care, Inc.**ID #** 00502211CDD **Phone:** (585) 244-3650

AUTHORIZED HEALTH CARE PROVIDER TO COMPLETE:

- Prescriber's Name:_____
- Prescriber's Telephone Number:_____
- Name of Medication (including strength if applicable):_____
- Amount, Dosage, and Route of Administration:_____
- Date to be Discontinued or Length of Time to be Given (up to 6 months):_____
- Time(s) to be Administered (for non-PRN Medication):_____
- Refrigeration Required: ___Yes ___No
- Reason for Taking Medication (unless confidential by law):_____
- Possible Side Effects:_____
- What Action to Take if Side Effects are Noted:_____
- 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 related to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered):_____

  _____
- Identify the Symptoms that will Necessitate Administration of Medication (complete this section for as needed (PNR) Medication only):_____
- Provider's Signature:_____Date:_____

PARENTAL CONSENT/AUTHORIZATION:

I, _____authorize Rich Beginnings Child Care, Inc. to administer the medication listed
Parent/Legal Guardian

above to _____.
Child's Name

Parent or Legal Guardian's Signature: _____Date:_____

REQUIRED SIGNATURE:

I have reviewed this form for accuracy:

Child Care Provider's Name: _____Provider's Signature:_____Date:_____

<u>Complete this Section Only if Discontinuation Date is PRIOR to Date Listed Above:</u>

Medication Discontinuation Authorization:

I, _____request that the medication listed above be discontinued effective_____.
Parent/Legal Guardian *Medication Discontinue Date*

Parent/Legal Guardian Name:_____Signature:_____Date:_____

Written Medication Consent Form and Log of Administration

Log of Administration for: (to be used with the child's medication consent form)

CHILD'S NAME:_____ MEDICATION:_____

Date Given (M/D/Y)	Dose	Time (AM or PM)	Administered by (full signature)	Any Noted Side Effects	Parents notified of side effects	For "as needed" medication note the symptoms child exhibited that necessitated the need for the medication	Parents notified "as needed" medicine was given
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N
					Y N		Y N

Complete for medication not given when child is schedule for medication and present in the program
(for medication errors-parents must be notified and OCFS must be notified in writing)

Date Not Given	Description of reason why medication not given	Parents notified	Signature of Provider
		YES NO	
		YES NO	
		YES NO	