

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 (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 supply)					
<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 health care provider at phone number provided below			
<input type="checkbox"/> Other (describe): _____					
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply)					
<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 situation's when medication should not be administered.) _____					
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? <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: <b>X</b>					

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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? (For example, did the licensed authorized prescriber write 12pm?)  Yes  N/A  No

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 to administer the medication, as specified on the front of this form, to (child's name): \_\_\_\_\_

21. Parent's Name (please print): _____	22. Date Authorized: / /
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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: _____
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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 (please print): _____	29. Date Received from Parent: / /
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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 *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:  
**X**



NEW YORK STATE  
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**INDIVIDUAL HEALTH CARE PLAN  
 FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS**

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.


This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: <b>X</b>		

**Signature of Parent:**

<b>X</b>	Date:
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NEW YORK STATE  
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**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.

Child's Name: \_\_\_\_\_ Date of Plan:     /     /

Date of Birth:     /     /                      Current Weight:     lbs.

Asthma:  Yes (higher risk for reaction)    No

**My child is reactive to the following allergens:**

Allergen:	Type of Exposure: (i.e., air/skin contact/ingestion, etc.):	Symptoms include but are not limited to: (check all that apply)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)

If my child was **LIKELY** exposed to an allergen, for **ANY** symptoms:  
 give epinephrine immediately

If my child was **DEFINITELY** exposed to an allergen, even if no symptoms are present:  
 give epinephrine immediately

Date of Plan:        /        /

**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: _____

<b>EMERGENCY CONTACTS – CALL 911</b>	
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Ambulance: (     )     -	
Child’s Health Care Provider:	Phone #: (     )     -
Parent/Guardian:	Phone #: (     )     -

<b>CHILD’S EMERGENCY CONTACTS</b>	
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Name/Relationship:	Phone#: (     )     -
Name/Relationship:	Phone#: (     )     -
Name/Relationship:	Phone#: (     )     -

Parent/Guardian Authorization Signature:	Date:     /     /
Physician/HCP Authorization Signature:	Date:     /     /
Program Authorization Signature:	Date:     /     /