


OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION 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.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)
(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

1. Child's first and last name: Missy Franklin	2. Date of birth: 4-3-XX (6 months old)	3. Allergies: None known
4. Name of medication (including strength): Baby Orajel	5. Amount/dosage to be given: Small pea-size amount	6. Route of administration: apply to red or swollen gums

7A. Frequency to be administered: _____
OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when measurable parameter(s) **increased irritability, fussiness and/or red, swollen and painful gums; apply no more than 2 times a day while in care**)

8A. Possible side effects: See package insert for complete list of possible side effects (parent must supply)
AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:
 Contact parent Contact prescriber at phone number provided below
 Other (describe): _____

10A. Special instructions: See package insert for complete list of special instructions (parent must supply)
AND/OR

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): **Discomfort due to teething**

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
 No Yes If you checked 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 relates to the dose, time or frequency the medication is to be administered?
 No Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date prescriber authorized: 9/29/XX	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):
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16. Prescriber's name (please print): Dr. Margaret Valens	17. Prescriber's telephone number: (718) 555-2345
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18. Licensed authorized prescriber's signature:
X Margaret Valens, M.D.

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Updated 11-04

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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?) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm): _____		
20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to <u>Missy Franklin</u> <div style="text-align: right;">(child's name)</div>		
21. Parent or legal guardian's name (please print): Andrea Franklin	22. Date authorized: 9/29/XX	
23. Parent or legal guardian's signature: X <i>Andrea Franklin</i>		
DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)		
24. Provider/Facility name: ABC Child Care	25. Facility ID number: 01376 DCC	26. Facility telephone number: (212) 555-8363
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. Authorized child care provider's name (please print): Carla Carson	29. Date received from parent: 9/29/XX	
30. Authorized child care provider's signature: X <i>Carla Carson</i>		
ONLY COMPLETE THIS SECTION (#31 -#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15		
31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ <div style="text-align: right;">(date)</div> 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 the day care program staff will need to care for this child. _____ _____		
34. Licensed Authorized Prescriber's Signature: X		
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 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.		
36. Licensed Authorized Prescriber's Signature: X		

Case Study 2: Prescription Medication

Pharmacy Inc. #0012 Ph: 914-555-0102
100 Main Street, NYC, NY 10068
Rx#: 8145973-02 Tx: 8063264

Child

Jose Martinez DOB: 11/30/XX
(914) 554-1984
461 Park Place, Brooklyn, NY 11202

Medication

albuterol (90mcg/inh)
(generic form of Ventolin®)

Time / Route

Dose

Give **two puffs** by oral inhaler as directed. May give every four hours up to three doses per day.

Prescriber: **Nancy Wallace MD (914) 564-9832**
221 Stream Place, Brooklyn, NY 11202
Refillable: 0 times QTY: 1 R.Ph. Init: RSL
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/XX


1. Right Medication: albuterol 90 mcg/inh
2. Right Time: When José shows these symptoms: shortness of breath, wheezing, complaint of difficulty breathing. (Label states "as directed," so follow the health care provider instructions when matching the right time.)
3. Right Dose: 2 puffs
4. Right Route: inhaled by oral inhaler
5. Right Child: José Martínez



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- 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 (omit #18) for over-the-counter topical ointments, sunscreen and insect repellent)

<p>1. Child's first and last name: <u>José Martinez</u></p>	<p>2. Date of birth: <u>11-30-XX (6 years old)</u></p>	<p>3. Child's allergies: <u>Dust, pollen</u></p>
<p>4. Name of medication (including strength): <u>Albuterol 90 mcg/inh</u></p>	<p>5. Amount/dosage to be given: <u>2 puffs</u></p>	<p>6. Route of administration: <u>inhaled</u></p>

7A. Frequency to be administered: _____
OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when measurable parameters) difficulty breathing, wheezing, and/or shortness of breath. May repeat dose in four hours, if needed.

8A. Possible side effects: See package insert for complete list of possible side effects (parent must supply)
AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:
 Contact parent Contact prescriber at phone number provided below
 Other (describe): _____

10A. Special instructions: See package insert for complete list of special instructions (parent must supply)
AND/OR

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): Asthma

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
 No Yes If you checked 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 relates to the dose, time or frequency the medication is to be administered?
 No Yes If you checked yes, complete #35-#36 on the back of this form.

<p>14. Date prescriber authorized: <u>7/15/XS</u></p>	<p>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):</p>
<p>16. Prescriber's name (please print): <u>Dr. Nancy Wallace</u></p>	<p>17. Prescriber's telephone number: <u>(718) 564-9832</u></p>
<p>18. Licensed authorized prescriber's signature: X <u>Nancy Wallace, M.D.</u></p>	

This is a double-sided form

Updated 11-04

