

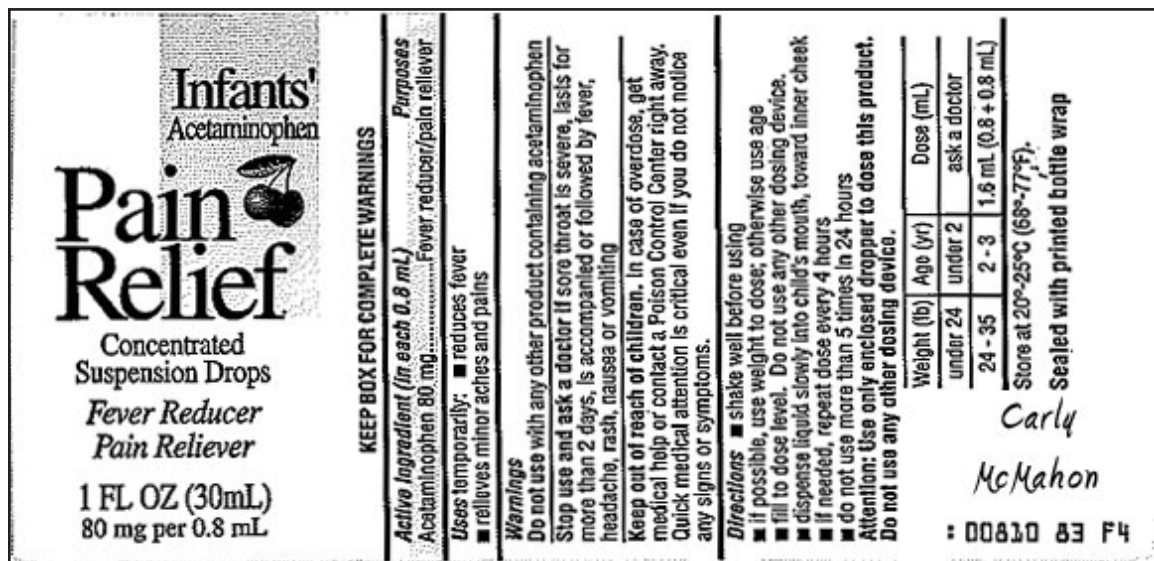
Exercise: Accepting Medication



Directions:

Pair up with another participant. Using your handouts, read each case study and answer the questions.

Case Study 1: Carly McMahon is a ten-month-old child in your program. When her mother drops her off, she tells you Carly is teething and is uncomfortable and irritable. She also says she spoke with Carly's doctor last night and the doctor recommended she give her Tylenol® for the pain. Her mother gives you a bottle of Infants' Acetaminophen Pain Relief Drops with Carly's name on it and asks you to give her a dose at 1PM today. She does not have a completed *Written Medication Consent Form* signed by Carly's health care provider.



Infants' Acetaminophen Pain Relief
Concentrated Suspension Drops
Fever Reducer
Pain Reliever
1 FL OZ (30mL)
80 mg per 0.8 mL

KEEP BOX FOR COMPLETE WARNINGS

Active Ingredient (in each 0.8 mL)
Acetaminophen 80 mg

Purposes
Fever reducer/pain reliever

Uses temporarily:

- reduces fever
- relieves minor aches and pains

Warnings
Do not use with any other product containing acetaminophen
Stop use and ask a doctor if sore throat is severe, lasts for more than 2 days, is accompanied or followed by fever, headache, rash, nausea or vomiting
Keep out of reach of children. In case of overdose, get medical help or contact a Poison Control Center right away. Quick medical attention is critical even if you do not notice any signs or symptoms.

Directions

- shake well before using
- if possible, use weight to dose; otherwise use age
- fill to dose level. Do not use any other dosing device.
- dispense liquid slowly into child's mouth, toward inner cheek
- if needed, repeat dose every 4 hours
- do not use more than 5 times in 24 hours

Attention: Use only enclosed dropper to dose this product. Do not use any other dosing device.

Weight (lb)	Age (yr)	Dose (mL)
under 24	under 2	ask a doctor
24 - 35	2 - 3	1.8 mL (0.8 + 0.8 mL)

Store at 20°-25°C (68°-77°F).
Sealed with printed bottle wrap

Carly
McMahon

: 00810 83 F4

1. Do you have the required instructions from Carly's doctor to accept the medication? How do you determine this?

If not, is there anything you can do so you can accept the medication from Carly's mother?

Case Study 2: Joshua Liebowitz is a four-year-old child in your program. You have been giving him a medication called carbamazepine every day at 12PM for the last nine months to prevent seizures. He has been doing very well and has not had a seizure since taking the medication. Today, Joshua's father drops him off and tells you Joshua's doctor wants to lower the amount of the carbamazepine Joshua takes. Joshua's father gives you new written instructions from the doctor (see next page) but does not have a new bottle of medicine, since there is still plenty of medicine left and the pharmacy won't fill a new prescription yet.


1. Do you have the required instructions from Joshua's doctor to accept the medication?

2. You see that Box 13 is checked on Joshua's consent form. The label on the carbamazepine bottle you have stored at the program does not match the dose written on the consent form. Do you need a new medication label that matches the new written health care provider instructions before you agree to give the medication?

What else do you need to do?

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: <i>Joshua Liebowitz</i>	2. Date of birth: <i>2/6/XXXX (4 years old)</i>	3. Child's known allergies: <i>None</i>
4. Name of medication (including strength): <i>Carbamazepine suspension (100mg/5ml)</i>	5. Amount/dosage to be given: <i>1 tsp</i>	6. Route of administration: <i>oral</i>
7A. Frequency to be administered: <i>12 noon</i>		
OR		
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 checked="" type="checkbox"/> 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: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input checked="" type="checkbox"/> 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): <i>seizure disorder</i>		
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? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete #35-#36 on the back of this form.		
14. Date prescriber authorized: <i>10/13/XXXX</i>	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): <i>4/13/XXXX</i>	
16. Prescriber's name (please print): <i>Dr. Gary Marchione</i>	17. Prescriber's telephone number: <i>(914) 555-1998</i>	
18. Licensed authorized prescriber's signature: X <i>Gary Marchione</i>		

This is a double-sided form **Updated 11-04**

OCFS-LDSS-7002 (11/2004)		NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES WRITTEN MEDICATION CONSENT FORM	
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>Joshua Liebowitz</u> (child's name)			
21. Parent or legal guardian's name (please print): <u>Gabriel Liebowitz</u>	22. Date authorized: <u>10/14/XXXX</u>		
23. Parent or legal guardian's signature: <input checked="" type="checkbox"/> <u>Gabriel Liebowitz</u>			
DAY CARE PROGRAM 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 the day care program.			
28. Authorized child care provider's name (please print):		29. Date received from parent:	
30. Authorized child care provider's signature: <input checked="" type="checkbox"/>			
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 _____ (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: <input checked="" type="checkbox"/>			
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. <u>See Individual Health Care Plan</u>			
34. Licensed Authorized Prescriber's Signature: <input checked="" type="checkbox"/> <u>Gary Marchione</u>			
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: <u>12/31/XXXX</u>			
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: <input checked="" type="checkbox"/> <u>Gary Marchione</u>			
This is a double-sided form		Updated 11-04	