NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

fill out Both Sides

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 PRESCRIB	ER COMPL	ETE THIS SEC	TION (#1 - #1	8) AND AS NEEDED (#33 - 35)
1. Child's First and Last Name:	2. Date	of Birth:	3. Child's Ki	nown Allergies:
4. Name of Medication (including strength):	5	. Amount/Dosage to	be Given:	6. Route of Administration:
7A. Frequency to be administered:	And the second s		San Daniel and Angle of South	
OR 7B. Identify the symptoms that will necessitate possible, measurable parameters):				s must be observable and, when
8A. Possible side effects: See package		plete list of possible	side effects (pa	rent must supply)
AND/OR				
8B: Additional side effects:				
9. What action should the child care provider to				X XXXXX
		are provider at phon	e number provid	ed below
10B. Additional special instructions: (Include a concerns regarding the use of the medication a situation's when medication should not be admi	as it relates to			
11. Reason for medication (unless confidential	l by law):		2 10 89/1,02/100/3	prince tensolistic via obtasci di
12. Does the above named child have a chron or more and requires health and related service				
☐ No ☐ Yes If you checked yes, complete	(#33 and #35) on the back of this	form.	
13. Are the instructions on this consent form a medication is to be administered?	change in a p	revious medication	order as it relate	es to the dose, time or frequency the
☐ No ☐ Yes If you checked yes, complete	e (#34 -#35) o	n the back of this fo	m.	
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 (p	lease print):	17. Licens	ed Authorized P	Prescriber's Telephone Number:
18. Licensed Authorized Prescriber's Signatur				

abia Hoof boolli

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES MEDICATION CONSENT FORM

MEDICATION CONSENT FORI CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the ins authorized prescriber write 12pm?)	structions indicate a specific es N/A No	time to administer	the medication? (For example, did the licensed	
Write the specific time(s) the child day car				
20. I, parent, authorize the day care progra	am to administer the medica	ation, as specified o	on the front of this form, to (child's name):	
21. Parent's Name (please print):		22. Date Authorized:		
23. Parent's Signature:				
CHILD DAY CARE PROGRAM C	OMPLETE THIS SECT	TION (#24 - #30)	30.0	
24. Program Name: 25. Facility ID Number: 263187			26. Program Telephone Number: 914 - 698 - 5632	
27. I have verified that (#1 - #23) and if ap this medication has been given to the day	plicable,(#33 - #36) are com care program.	plete. My signature	e indicates that all information needed to give	
28. Staff's Name (please print):	Corcoran		eceived from Parent:	
30. Staff Signature:	tofor six	abatta epia I inici :		
ONLY COMPLETE THIS SECTION (# PRIOR TO THE DATE INDICATED IN	#31 - #32) IF THE PAREN	NT REQUESTS T	O DISCONTINUE THE MEDICATION	
31. I, parent, request that the medication in		m be discontinued of	n	
Committee and the standard transfer and the			(Date)	
consent form must be completed.	ed, I understand that if my ch	hild requires this me	edication in the future, a new written medication	
32. Parent Signature:				
X				
LICENSED AUTHORIZED PRESC		THE RESERVE THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, AND T		
33. Describe any additional training, procedure	dures or competencies the o	day care program s	taff will need to care for this child.	
e equilibre expected to see 12 month	t in the Kaleman	aved lader i nico	de secondo chero de la respecto de companyo de la la companyo de la companyo della companyo della companyo della companyo de la companyo della companyo dell	
9 E 100 20 10 10 10 10 10 10 10 10 10 10 10 10 10		11000000		
ard varioupers to easily each to the operation	nous media	siq ii Tif signa ip ee		
34. Since there may be instances where the frequency until the medication from the prescription to take DATE:	vious prescription is comple	w prescription for cletely used, please in	hanges in a prescription related to dose, time or ndicate the date you are ordering the change in	
By completing this section, the day care pronew prescription has been filled. 35. Licensed Authorized Prescriber's Signal		instruction on this	form and <i>not</i> follow the pharmacy label until the	
X	au.c.			

OCFS-LDSS-7006 (5/2014) FRONT

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

* Parent Fill out

FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS TOUR

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
escribe the special health care needs of the ealth care provider. This should include information shared post enrollment.	nis child and the plan of care as identified by the parent and the child's formation completed on the medical statement at the time of enrollment
	the decidence of the continue
	bling art of noticed partitions the substitute of the substitute and
e intered is priviled beginning and or before	den had to provide all treatments and administer medication to the child
e intered is priviled beginning and or before	den fiss to provide all treatments and administer medication to the child the straight south of the child one obtained and medication in adcordance of measurements of the committee at on treatment and medication in adcordance of medication remover. Occupation
steed in the specialized individual magin or pour pour property and have demonstrated in the plan identified.	den had to provide all treatments and administer medication to the child
representation to the participation of the second transfer of the plan identified the second transfer of the secon	den fiss to provide all treatments and administer medication to the child the straight south of the child one obtained and medication in adcordance of measurements of the committee at on treatment and medication in adcordance of medication remover. Occupation
e interest is univibrit bacisioeus en in befet enterest is and house parten grimmer vanue backterobi nate en intro- trace en en interest care en en en interest	Here field to travide all treatments and administer medication to the child and account of the child and account of the child and account of the child and treatment and medication in ascordance. The complete state of the child and the chil
e ritioen isconishiri baciisiosus sin in berst attendina a on bis patition grimmi vanua battioni naig siti ritio recordina in ritional recordina con sign in the	the first to provide all treatments and administer medication to the child the structure and the child care regularization of news requirements of news requirements of additional in accordance in the providence of the providence

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

escribe any additional training, procedures or competencies the caregiver identified will need to carry out the health are plan for the child with special health care needs as identified by the child's parent and/or the child's health care ovider. This should include information completed on the medical statement at the time of enrollment or information hared post enrollment. In addition, describe how this additional training and competency will be achieved including the will provide this training.
lateral process and margaretic of the control of the stress of the stres

	rict of the dryches are mission is office brisish	oreq a birt and after a second Passa palable
	uja neads ofi Otida paga u	Div bol so isser or here and the bold of wolld
		nechtors stroctthed elections of the email
	D Physical Carlotte	
s'bikio edi bresinanen evo	1 000 1197 L. J.	
s units on the sale profession of	is only and use jash or care a color of the	kii 'O aboon sasa miser aspesi sa secolese Kai obulon birone ek? Tasasana sasa mise
		roy seen thereo, ort amounters
		ration of the control
		realization of the contract of
n are familiar with the child o	se collaboration with the child's parent and ents and administer medication to the child are regulations and have received any add treatment and medication in accordance	the child's health care provider. The caregived listed in the specialized individual health californial training needed and have demonstrative with the plan identified.
npetency to administer such	and the second delice	man and plain identified.
npetency to administer such ogram Name: EEPS INC.	License/Registration Number: 263187	Program Telephone Number:
npetency to administer such ogram Name: EEPS INC. ild care provider's name (please p	License/Registration Number: 263187	
npetency to administer such ogram Name: EPS INC. Id care provider's name (please p	License/Registration Number: 263187	Program Telephone Number: 914-698-5632
ogram Name: EEPS INC. illd care provider's name (please provider's signature:	License/Registration Number: 263187	Program Telephone Number: 914-698-5632 Date: