

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
MEDICATION CONSENT FORM
CHILD DAY CARE PROGRAMS

Doctor + Parent
fill out Both Sides

- 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:					
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 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 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)					
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 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: X					

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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: _____

23. Parent's Signature: _____

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name: _____

KEEPS Inc

25. Facility ID Number: _____

263187

26. Program Telephone Number: _____

914-698-5632

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): _____

Noreen Corcoran

29. Date Received from Parent: _____

30. Staff Signature: _____

X

Noreen Corcoran

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

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

★ Parent fill out
NEEDS form

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.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	Child date of birth:
Name of the child's health care provider:	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and 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.

Date case was opened: Date case was closed:		Patient's name (Please print) Patient's address Patient's phone number	Patient's date of birth Patient's sex Patient's race	Patient's insurance company Patient's insurance policy number Patient's insurance group number	Patient's primary care physician Patient's specialty Patient's referral source
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Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

Describe any additional training, procedures or competencies the caregiver has used to manage the child's behavior.

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: KEEPS INC.	License/Registration Number: 263187	Program Telephone Number: 914-698-5632
Child care provider's name (please print): Noreen Corcoran		Date:
Child care provider's signature: X <i>Noreen Corcoran</i>		

X	Date:
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