Group Activity: Receiving Medication, Scenario 1

Nick is 15-months-old and has an ear infection. Nick needs a noon time dose of amoxicillin suspension for this week and part of next week. The medication requires refrigeration and it must be shaken before being given. Nick has already received several doses of amoxicillin at home.

- Divide the participants into pairs. Have 1 person play the parent and 1 receive the medication.

- Materials
  - Labeled “amoxicillin” in containers
  - Medication Packet with completed Authorization to Give Medicine and Receiving Medication with child’s name on top that participants will complete
  - Completed Universal Child Health Record
  - Storage box to place medication (assume that it is locked)
  - Measuring devices

- Conclude the activity with the instructor posing “What if” questions like:
  - “What if the amoxicillin came as chewable tablets that were in a Ziploc® bag with Nick’s name handwritten on it?”
  - “What if the permission form was incomplete?”

- Answer: The medication should not be accepted until the problem is fixed.

Instructor Note:

For activity, make 2 demonstration models:

- Ziploc® bag with tablet inside with Nick’s name written on it
- Incomplete Authorization to Give Medicine form
Group Activity: Receiving Medication, Scenario 1

Take one teaspoon by mouth three times daily for 10 days

Shake before using.

Amoxicillin Suspension 250 mg/5 cc

NO REFILLS - DR. AUTHORIZATION REQUIRED

USE BEFORE 06/2020
Group Activity: Receiving Medication, Scenario 1

Medication Administration Packet

Authorization to Give Medicine

PAGE 1—TO BE COMPLETED BY PARENT

CHILD’S INFORMATION

ABC Child Care Center

Name of Facility/School: Nick Sample

Name of Child (First and Last): Amoxicillin Suspension

Name of Medicine: 250mg / 5cc

Reason medicine is needed during school hours: Ear Infection

Dose: One teaspoon

Route: By mouth

Time to give medicine: Noon

Additional instructions

Date to start medicine: 01/01/20xx

Stop date: X/1/20xx

Known side effects of medicine: Diarrhea

Plan of management of side effects: Rice cereal and yogurt to eat

Child allergies: None

PREScriber’S INFORMATION

Elaine Donoghue, MD

Prescribing Health Professional’s Name

(132) 775-5600

Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.

Nicole Sample

Parent/Guardian Name (Print)

Nicole Sample

Parent/Guardian Signature

123 Main Street, Anywhere, USA

Address

123-4567 234-5678 987-6543

Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.
Group Activity: Receiving Medication, Scenario 1

UNIVERSAL CHILD HEALTH RECORD

SECTION I - TO BE COMPLETED BY PARENT(S)

<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>Sample</th>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>(First)</td>
<td>Nick</td>
<td></td>
<td></td>
<td></td>
<td>1/1/2004</td>
</tr>
</tbody>
</table>

Does Child Have Health Insurance? [ ] Yes [ ] No
If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name: Nicole Sample
Home Telephone Number: (123) - 456-7

Parent/Guardian Name: Michael Sample
Home Telephone Number: (123) - 456-7

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date: Nicole Sample

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: 2/21/2002
Results of physical examination normal? [ ] Yes [ ] No

Abnormalities Noted:

- [ ] Immunization Record Attached
- [ ] Date Next Immunization Due: 2 years of age

IMMUNIZATIONS

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries
- List medical conditions/ongoing surgical concerns:

Medications/Treatments
- List medications/treatments:

Limitations to Physical Activity
- List limitations/special considerations:

Special Equipment Needs
- List items necessary for daily activities

Allergies/Sensitivities
- List allergies:

Special Diet/Vitamin & Mineral Supplements
- List dietary specifications:

Behavioral Issues/Mental Health Diagnosis
- List behavioral/mental health issues/concerns:

Emergency Plans
- List emergency plan that might be needed and the signs/symptoms to watch for:

PREVENTIVE HEALTH SCREENINGS

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td>12/1/2002</td>
<td>11.3g</td>
<td>Hearing</td>
<td>Brain</td>
<td>Passed</td>
</tr>
<tr>
<td>Lead: [ ] Capillary</td>
<td>12/1/2002</td>
<td>3</td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous</td>
<td></td>
<td></td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td>Developmental</td>
<td>12/1/2002</td>
<td>Normal</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print): Elaine Donoghue, MO

Signature/Date: Elaine Donoghue

Health Care Provider Stamp: CH-14 SEP 08

Distribution: Original - Child Care Provider, Copy - Parent/Guardian, Copy - Health Care Provider
Group Activity: Receiving Medication, Scenario 1

Receiving Medication
PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child: Nick Sample

Name of medicine: Amoxicillin Suspension 250/5 cc

Date medicine was received: 1/1/20xx

Safety Check


☐ 2. Original prescription or manufacturer’s label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature
**Medication Administration Packet**

**Authorization to Give Medicine**

**PAGE 1---TO BE COMPLETED BY PARENT**

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<td>Nick Sample</td>
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<tr>
<td>Name of Child (First and Last)</td>
<td></td>
</tr>
<tr>
<td>Name of Medicine</td>
<td>Amoxicillin Suspension 250 mg/5 cc</td>
</tr>
<tr>
<td>Reason medicine is needed during school hours</td>
<td>Ear infection</td>
</tr>
<tr>
<td>Dose</td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td>By Mouth</td>
</tr>
<tr>
<td>Time to give medicine</td>
<td>Noon</td>
</tr>
<tr>
<td>Additional instructions</td>
<td></td>
</tr>
<tr>
<td>Date to start medicine</td>
<td>01/01/20xx Monday</td>
</tr>
<tr>
<td>Stop date</td>
<td>01/31/20xx</td>
</tr>
<tr>
<td>Known side effects of medicine</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Plan of management of side effects</td>
<td>Rice cereal and yogurt to eat</td>
</tr>
<tr>
<td>Child allergies</td>
<td>None</td>
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<tbody>
<tr>
<td>Elaine Donovan MD</td>
</tr>
<tr>
<td>Prescribing Health Professional’s Name</td>
</tr>
<tr>
<td>(732) 775-5500</td>
</tr>
<tr>
<td>Phone Number</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>123 Main St., Anywhere, USA</td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>123-4567</td>
</tr>
<tr>
<td>Work Phone Number</td>
<td>234-5678</td>
</tr>
<tr>
<td>Cell Phone Number</td>
<td>987-6543</td>
</tr>
</tbody>
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