MODULE 2
Preparation

• Forms
• Policies
• Confidentiality
• Receiving and storing medication
• Disposing of medication
<table>
<thead>
<tr>
<th>Activity</th>
<th>Methods</th>
<th>Participant Materials</th>
<th>Other Materials or Supplies</th>
<th>Slide Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample Policy</strong></td>
<td>Optional: Group Activity</td>
<td>Policy in Manual</td>
<td></td>
<td>12</td>
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<tr>
<td><strong>Floor Plan</strong></td>
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<td>Floor plan in Manual</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td><strong>Receiving Medication, Scenario 1</strong></td>
<td>Group Activity</td>
<td></td>
<td>Labeled “amoxicillin” in container, <em>Completed Medication Packet with completed Authorization to Give Medicine and Receiving Medication, Universal Health Record</em>, storage box, measuring devices, Ziploc® bag with tablet inside and Nick’s name on outside, <em>incomplete Authorization to Give Medicine</em></td>
<td>29</td>
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<tr>
<td><strong>Receiving Medication, Scenario 2</strong></td>
<td>Group Activity</td>
<td></td>
<td>Labeled “Aveeno®” in container, <em>Completed Medication Packet with Authorization to Give Medicine and Receiving Medication, Universal Health Record</em>, storage box, cream with instructions blocked by Maria’s name on outside, <strong>incomplete Authorization to Give Medicine</strong></td>
<td>30</td>
</tr>
</tbody>
</table>
**MODULE 2**

**Preparation**

- Forms
- Policies
- Confidentiality
- Receiving and storing medication
- Disposing of medication

**Objectives**

A. **Knowledge**: Each participant will be able to:
   1. Summarize the forms a child care provider needs before giving medication
   2. Identify policies that must be in place before receiving medication
   3. Understand why information about medication should be kept confidential as ordered by federal law
   4. Describe safe practices of where to store and dispose of medication

B. **Attitude**: Each participant will be able to:
   1. Feel knowledgeable about receiving and disposing of medication

C. **Behavior**: Each participant will:
   1. Review a Child Health Assessment and Authorization to Give Medicine form
**Background:**
- Walk participants through each of the required forms in the Participant's Manual.
- Some states embed a release to talk to the health care professional into the Emergency Contact Form, while in other states, separate forms for each purpose are required.
- Some states require a health care professional’s signature to give medication (prescription and OTC), and some states use the same form for both prescription and OTC, while other states use different forms for each type.
- Review state-specific information.
- Your state regulations can be obtained at the National Resource Center for Health and Safety in Child Care and Early Education (NRC) Web site (http://nrckids.org/STATES/states.htm).
- The following quote from the NRC might be helpful to read:
  “The multiple forms and signatures required [that we are about to discuss] seem quite ‘formal’ and are sometimes confusing to both care providers. It is important to recall that the role of the child care provider is a professional one and is distinct from the role of the parent. The rules and forms exist to protect the child, the parent and the child care provider against harmful mistakes. Once this is clear, the forms will seem more friendly.” National Resource Center for Health and Safety in Child Care, Medication Administration in Child Care.

**CFOC, Standard 9.2.3.9**
“A medication record maintained on an ongoing basis by designated staff shall include the following:
- Specific, signed parental/guardian consent for the caregiver/teacher to administer medication including documentation of receiving controlled substances and verification of the amount received;
- Specific, signed authorization from the child’s prescribing health professional, prescribing the medication, including medical need, medication, dosage, and length of time to give medication.
- Information about the medication including warnings and possible side effects;
- Written documentation of administration of medication and any side effects;
- A medication error log should be started if there is a side-effect, error or any other problem with giving the medication.
**Speaker's Notes:**

- The Child Health Assessment is a general form geared towards healthy children.
  - Other names for this form include Individual Health Plan or “the physical” form.

- Best practice states that the Child Health Assessment should be **updated** annually or when there is a change in health status, such as a hospitalization.

- Specific disease action plans are not covered in this training and are included for reference only.

**Background:**

- Review state-specific information.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
- **Every state is different** as to what must be included, the timeframe for completion, and the length of time that the form remains valid.
- While licensing regulations in some states allow 30 days for the completion of the child’s health assessment, **best practice** dictates that a child care provider have that information at the time of enrollment in order to have adequate information about the child to properly care for him or her, particularly if special needs are involved.
Speaker's Notes:

- Children with special health care needs should have a care plan or individualized health plan that outlines the specifics of their special health care needs.

- Some care plans are general, such as the Emergency Information Form for Children with Special Needs, and others are disease-specific, like an Asthma Action Plan.

- Examples of care plans are available in the Additional Resources in the Participant’s Manual.

- Specific disease action plans are not covered in this training and are included for reference only.
**Speaker's Notes:**

- **CFOC, Standard 3.6.3.1, states** “The administration of medicines at the facility shall be limited to:
  
a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication as well as any special instructions.
  
b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).

**Background:**

- Review state-specific information.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
**Background:**
- This topic will be covered in more detail later in this module.
**Background:**
- The Medication Log will be covered in more detail in Module 4, Documentation.
Speaker's Notes:

The Emergency Contact Form:

- May be include the child’s **insurance** information
- May be **combined** with other forms

While permission to speak with the health care professional is on the Medication Administration Packet, Authorization to Give Medicine form, the need to do so may also occur for children who are not receiving medication and so it has been included on the Universal Child Health Record and the Emergency Contact Form as well.
**Background:**

- Discuss **state-specific regulations** concerning health care professional’s orders.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
- **The National Association for the Education of Young Children** (NAEYC) regulations state: “The program may have a **standing order** from a licensed health care provider to guide the use of OTC medications with children in the program when the order details specific circumstances and gives specific instructions for individual dosing of the medication.”
Speaker's Notes:

• "As needed" or "prn" orders are frequently written by health care professionals to allow a nurse to give a medication only when nursing judgment deems that the medication is needed.
  o These types of instructions must be much more specific for non health care professionals. For example: “Give albuterol nebulizer treatment every 4 hours as needed” versus “Give albuterol nebulizer treatment every 4 hours for increasing cough, rapid breathing, chest tightness, or other signs of respiratory difficulty.”
  o Health care professionals are used to writing “prn” orders for school nurses and may not realize that a nurse might not be available at a child care site to make trained decisions about when to administer medication.

• This subject is discussed in more detail later in this module and in Module 3, How to Administer Medication.

**Background:**

• CFOC, Standard 3.6.3.1: “Telephone instructions from a health care provider are acceptable if the caregiver fully documents them and the parent initiates the request.”

• Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
Speaker’s Notes:
• If the health care professional’s order does not list the possible side-effects or adverse reactions, information can be obtained from the pharmacy or other reliable sources of information about medication.

• The reason for the medication is protected health information but may be helpful to know. The parent can share this information at their discretion.

**Background:**
• Refer to Sample Prescription Label and Sample OTC Label in Module 2, Preparation in the Participant’s Manual.
**Speaker's Notes:**

- Every parent should receive and sign a copy of the policy.
- It can be attached to the authorization form.
- Parents can be requested to share the Authorization to Give Medicine and policy with their health care professional, especially if it is likely that medication will be prescribed.
- All staff should be familiar with the policy and forms even if they do not give medication.
- A Child Care Health Consultant may be available to review the child care policy and make suggestions.

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**Optional Activity: Sample Policy**

- Refer to the Sample Policy Activity in the Participant's Manual, Module 2, for activity instructions and materials.
- This activity is long and in depth.
- Consider doing this activity if the participants include center directors, or if participants have a specific interest in policy development.

**Background:**

- Emphasize that policy should be in writing.
- Check state regulations and add pertinent state requirements.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
- Refer participants to the Medication Administration Policy Checklist in the Participant's Manual, Module 3, How to Administer Medication.
**Speaker’s Notes:**

- **The policy should state** that the **director of the child care center designates** who will be responsible for administering medication.

- **It is best practice to assign only one person per day or shift to administer medication** in order to avoid confusion, errors, double dosing, or missed dosing.

- **Staff should have the skills** necessary to administer medication. They should be able to read well, measure items, and follow instructions.

- **Best practice** would be to include in the policy that those designated individuals must receive training in medication administration (see CFOC, Standard 3.6.3.3).

- **Policy should state the circumstances when parents will be called to administer medication or when a nurse is required.**

- **Policy should address whether self-administration** will be allowed for older children, especially in after-school programs. This issue is addressed further in Module 5, Problem Solving.

**Background:**

- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
**Speaker's Notes:**

- **Homeopathic and herbal medications** do not have the same manufacturing safeguards as other medication.
  - Their use should be safeguarded by having a **prescription from an authorized health care professional** and requiring **proper labeling** about strength of medication, expiration date, side-effects, etc.

**Background:**

- If desired, discuss participants’ experiences of non-appropriate requests for medication administration (non-essential, off-label, or folk remedies) and how they responded.
**Speaker’s Notes:**

- **The 5 rights** will be discussed in Module 3, How to Administer Medication, but they include the right child, the right medication, the right dose, the right time, and the right route.

- **Suggested forms** were discussed in Module 2, Preparation. The policy should be specific about which forms are used, time frame for completion, and length of time for which they are valid.

- Giving the **first dose at home** allows parents to watch for immediate side-effects to the medication and to see how well the child accepts the medication.

- **Errors and Incidents** will be discussed further in Module 5, Problem Solving.

- The policy should be very clear on all these points.
Speaker’s Notes:
• **Knowing why a medication is being given** is important but may come into conflict with the child’s and family’s right for privacy.
  o **Respect a parent’s choice** to disclose information.

**Background:**
• Discuss relevant state or local statute, regulation or policy.
• Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
• Reinforce the responsibility as described in CFOC, Standard 9.2.3.6:
  o “Serving children and families involves significant responsibilities in obtaining, maintaining and sharing confidential information.”
  o “Sharing should be selective, on a “need to know” basis and on the parent’s authorization of disclosure.”
Speaker’s Notes:
- HIPAA requires
  - Secure transfer of medical records
  - Permission required for electronic transfer of medical records
  - Confidential treatment of medical records
- Once HIPAA-protected information is received by a school, it falls under FERPA rules.
- School staff with a "right to know" (i.e., have a direct relationship to the student’s academic performance) may have access to this information.
- The school can appoint an information gatekeeper as an intermediary with staff.
Speaker's Notes:

- Instructions for administration include the dose of the medication, the route (by mouth, etc), the frequency/time, the duration of treatment, and any specific instructions. Some examples include:
  - 5cc (1 teaspoon) by mouth every 12 hours for 10 days.
  - Apply a thin layer of cream to affected area 3 times a day for 10 days. Cover area with a bandage after applying.

**Background:**
- Refer to Sample Prescription Label and Sample OTC Label in Module 2, Preparation in the Participant’s Manual.
**Background:**

- CAUTION: In May, 2011, a move to one standard concentration (160 mg/5 ml) of liquid acetaminophen medicine for infants and children was announced. Up until that time, there were mainly 2 concentrations:
  - 80 mg/0.8 ml (Infant Concentrated Drops) and
  - 160 mg/5 ml (Children's Liquid Suspension or Syrup).
- Old concentrations (80mg/0.8 ml) of infant acetaminophen may still be available in some homes. Therefore, if it is an older product, please confirm the correct concentration.

More information at: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm284563.htm

- Refer to Sample Prescription Label and Sample OTC Label in Module 2, Preparation in the Participant’s Manual.
- Discuss specific state requirements on prescriber authorization for OTC medication.
- Prescriber authorization for OTC medication is best practice even if it is not state regulation.
- Prescriber authorization can be required by policy even if it is not part of your state regulations.
- Your state regulations can be obtained at the NRCWeb site (http://nrckids.org/STATES/states.htm).
Speaker's Notes:

- In all settings, including after school programs, medication should be transported and transferred from adult to adult, not by children.

- Include information on the last dose given. The last dose that the parent/guardian gave can be jotted in the margin.

**Background:**

- Emphasize that the parent/guardians should be asked the questions regarding the last dose of medication EVERY day and not just on receipt of the medication.
- Parents should also be asked frequently about any new side-effects that they have observed in their children since side-effects don’t always show up in the beginning.
**Speaker’s Notes:**

- The safety checklist is included in the Medication Administration Packet which is in the Participant’s Manual.

- The safety checklist includes:
  - Correct first and last name of child
  - Child resistant container
  - Original prescription or label with name and strength of medication
  - Medication not expired
  - Name and phone number of licensed health care professional
  - Child health record on file
  - Instructions for dose, route, and time
  - Storage instructions
  - Previous trial dose?
  - Controlled substance?

- Using an intake form can eliminate problems particularly in programs where the person greeting the child is not the designated medication administration person, such as in an early morning situation.

- All items are checked to see that there is consistency before accepting and administering the medication.

- Sometimes parents and child care providers will both need to sign the form to document that the medication was received.
**Speaker's Notes:**

- Some centers may only accept an *unopened container* of OTC medication as part of their policy.

- Examples of *special storage* instructions:
  - Avoid exposure to light or sunlight (generally these medications are packaged in dark containers)
  - Refrigerate/do not refrigerate
Speaker's Notes:

- Having medication at the child care site:
  - Helps to prevent missing a dose because medication was left at home
  - Keeps medication secure and out of the hands of children
  - Keeps medication climate controlled
**Background:**
- Double click the arrow to view video.
Optional Group Activity: Floor Plan

- Refer to Floor Plan: Where to Store Medication in the Participant’s Manual.
- Ask participants to identify where to store the following items:
  - Prescription medication
  - OTC medication
  - Emergency medication
  - Preventive substances (sunscreen, etc)

**Background:**
- State regulations may be specific about storage. Check your state’s regulations.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
- Medication must be kept out of the reach of children. The following quote underscores this concept:
  “As few as 5 adult vitamins with iron in them can cause death in a very young child,” Hawke, M., RN, MA, "Kids and Poison: Preventing a Fatal Attraction” Nursing Spectrum, December 2001.
- If not used and stored properly, any medication has the potential to be toxic or harmful to a child.
- CFOC, Standard 3.6.3.2 recommends a locked box in the refrigerator to assure safety.
- Topical medication should be separated from oral medication so topical medication is not accidently given by mouth.
Staff Medication

- Staff medication should be stored safely and should not be accessible to children
- Staff medication should not be kept in unsecure purses or bags
**Background:**
- Check your state regulations.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).

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Exceptions to Locked Storage

- Non-prescription diaper creams
- Non-prescription sunscreen
- Emergency medications (EpiPen®, asthma rescue medications, Glucagon®, Diastat®)
  - Emergency medications should stay close to children and can be stored in a pouch that stays with a supervising adult
- All of the medication listed above must be stored out of the reach of children
Create a Safe Medication Administration Area

A safe medication area is:
- Situated where the designated medication administration person is able to concentrate on administering medication
- Stocked with medication and supplies within easy reach
- Clean, well lit, and free of clutter
- Confidential and quiet
Speaker's Notes:
• Reasonable effort should be made to return the medication to the parent.
• How and when the medication was disposed of should be noted on the Medication Log or the permission form.
• Sometimes parents must sign to verify they received the returned, unused medication.
• It is no longer considered advisable to dispose of medication in the sink or toilet because of water contamination. Some communities have hazardous waste disposal plans.
• If disposing of medication in trash, consider mixing it with coffee grounds, pet litter, or other undesirable substance.
• Remove all identifying information from the container before disposing of medication.
• Empty inhalers should go in a secured trash container.
• All controlled substances must be accounted for. Special efforts should be made to return these to the parent or guardian and both parties should sign to account for the medication. Witnesses should sign for the disposition of controlled medication whether they are returned to parents or destroyed.

**Background:**
• Discuss state licensing regulations for disposing of medication.
• Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
Group Activity: Receiving Medication, Scenario 1

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

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

• Conclude the activity with the instructor posing “What if” questions like:
  o “What if the amoxicillin came as chewable tablets that were in a Ziploc® bag with Nick’s name handwritten on it?”
  o “What if the permission form was incomplete?”
  o Answer: The medication should not be accepted until the problem is fixed.

**Background:**
• For activity, make 2 demonstration models:
  o Ziploc® bag with tablet inside with Nick’s name written on it
  o Incomplete Authorization to Give Medicine form
Scenario 2: Maria

- Maria is 3-years-old and has eczema. She needs hydrocortisone cream applied to her arms at noon time. This is an OTC medication with a brand name of Aveeno®. Aveeno® also makes other non-medicated skin moisturizers as well, but the medication that is being requested is an OTC hydrocortisone cream. Maria has had this medication before.

Group Activity: Receiving Medication, Scenario 2
- Switch roles from Scenario 1: Nick.
- Materials
  - Labeled “Aveeno®” 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)
- Conclude the activity with the instructor posing “What if” questions like:
  - “What if the label with Maria’s name blocked the instructions?”
  - “What if the permission form was incomplete?”
  - Answer: The medication should not be accepted until the problem is fixed.

Background:
- For activity, make 2 demonstration models:
  - Cream with instructions blocked by Maria’s name
  - Incomplete Authorization to Give Medicine
# Medication Administration Packet

## Authorization to Give Medicine

**PAGE 1—TO BE COMPLETED BY PARENT**

<table>
<thead>
<tr>
<th>CHILD’S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Facility/School</td>
</tr>
<tr>
<td>Name of Child (First and Last)</td>
</tr>
<tr>
<td>Name of Medicine</td>
</tr>
<tr>
<td>Reason medicine is needed during school hours</td>
</tr>
<tr>
<td>Dose</td>
</tr>
<tr>
<td>Time to give medicine</td>
</tr>
<tr>
<td>Additional instructions</td>
</tr>
<tr>
<td>Date to start medicine</td>
</tr>
<tr>
<td>Known side effects of medicine</td>
</tr>
<tr>
<td>Plan of management of side effects</td>
</tr>
<tr>
<td>Child allergies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRESCRIBER’S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Health Professional’s Name</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
</tbody>
</table>

**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.**

| Parent or Guardian Name (Print) | |
| Parent or Guardian Signature | |
| Address | |
| 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.
Receiving Medication
PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child ____________________________________________________________________________________
Name of medicine _________________________________________________________________________________
Date medicine was received _____/_____/_____

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 Log

**PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER**

Name of child ____________________________________________________ Weight of child_______________________

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
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<tbody>
<tr>
<td><strong>Medicine</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date</strong></td>
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<tr>
<td><strong>Actual time given</strong> AM _______ AM _______ AM _______ AM _______ AM _______ PM _______ PM _______ PM _______ PM _______</td>
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<tr>
<td><strong>Dosage/amount</strong></td>
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<tr>
<td><strong>Route</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff signature</strong></td>
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</tbody>
</table>

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Error/problem/reaction to medication</th>
<th>Action taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Caregiver/teacher signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

RETURNED to parent/guardian

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Error/problem/reaction to medication</th>
<th>Action taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Caregiver/teacher signature</th>
</tr>
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<tbody>
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</table>

DISPOSED of medicine

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Error/problem/reaction to medication</th>
<th>Action taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Caregiver/teacher signature</th>
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The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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UNIVERSAL
CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child’s Name (Last) (First)

Gender

Date of Birth / / 

Does Child Have Health Insurance?

Yes  No

If Yes, Name of Child’s Health Insurance Carrier

Parent/Guardian Name

Home Telephone Number

Work Telephone/Cell Phone Number

Parent/Guardian Name

Home Telephone Number

Work Telephone/Cell Phone Number

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

This form may be released to WIC.

Yes  No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:

Results of physical examination normal?

Yes  No

Abnormalities Noted:

Weight (must be taken within 30 days for WIC)

Height (must be taken within 30 days for WIC)

Head Circumference (if <2 Years)

Blood Pressure (if ≥3 Years)

IMMUNIZATIONS

□ Immunization Record Attached  □ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries

• List medical conditions/ongoing surgical concerns:

□ None  □ Special Care Plan Attached  Comments

Medications/Treatments

• List medications/treatments:

□ None  □ Special Care Plan Attached  Comments

Limitations to Physical Activity

• List limitations/special considerations:

□ None  □ Special Care Plan Attached  Comments

Special Equipment Needs

• List items necessary for daily activities

□ None  □ Special Care Plan Attached

Allergies/Sensitivities

• List allergies:

□ None  □ Special Care Plan Attached

Special Diet/Vitamin & Mineral Supplements

• List dietary specifications:

□ None  □ Special Care Plan Attached

Behavioral Issues/Mental Health Diagnosis

• List behavioral/mental health issues/concerns:

□ None  □ Special Care Plan Attached

Emergency Plans

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

□ None  □ Special Care Plan Attached

PREVENTIVE HEALTH SCREENINGS

Type Screening  Date Performed  Record Value  Type Screening  Date Performed  Note if Abnormal

Hgb/Hct

Hearing

Lead: □ Capillary  □ Venous

Vision

TB (mm of Induration)

Dental

Other:

Developmental

Other:

Scoliosis

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)

Health Care Provider Stamp:

Signature/Date

CH-14  SEP 08

Distribution: Original-Child Care Provider  Copy-Parent/Guardian  Copy-Health Care Provider
Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

   - Weight - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - Height - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - Head Circumference - Only enter if the child is less than 2 years.
   - Blood Pressure - Only enter if the child is 3 years or older.

2. Immunization - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.

   - The Immunization record must be attached for the form to be valid.
   - “Date next immunization is due” is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. Medical Conditions - Please list any ongoing medical conditions that might impact the child’s health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow. A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. Medications - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

   Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. Limitations to physical activity - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. Special Equipment - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. Allergies/Sensitivities - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. Special Diets - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. Behavioral/Mental Health issues – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. Emergency Plans - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. Screening - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children’s health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.

   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.

   - Scoliosis screenings are done biannually in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

   - Print the health care provider’s name.

   - Stamp with health care site’s name, address and phone number.

CH-14 (Instructions)
SEP 08
# Emergency Contact Form

**To Be Completed By Parent(s)**

<table>
<thead>
<tr>
<th>Date form completed</th>
<th>Revised</th>
<th>Initials</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Birth Date:</th>
<th>Nickname:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone Number:</td>
<td>Work/Cell Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact Names &amp; Relationship:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone Number:</td>
<td>Work/Cell Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Primary Language:</td>
<td>Phone Number(s):</td>
<td></td>
</tr>
<tr>
<td>Physicians:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician:</td>
<td>Emergency Phone:</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Specialty Physician:</td>
<td>Emergency Phone:</td>
<td></td>
</tr>
<tr>
<td>Specialty:</td>
<td>Fax:</td>
<td></td>
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<td>Current Specialty Physician:</td>
<td>Emergency Phone:</td>
<td></td>
</tr>
<tr>
<td>Specialty:</td>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

**Does the Child Have Health Insurance?**

- [ ] Yes
- [ ] No

I give my consent for my child’s Health Care Provider and Child Care Provider to discuss information on this form.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>
Drug Facts

Active ingredient
Hydrocortisone 1%

Purpose
Anti-Itch

Warnings (continued)
Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions
* adults and children 2 years and older: apply to affected area not more than 3-4 times daily
* children under 2 years of age: do not use, ask a doctor

Inactive ingredients
Aloe barbadensis leaf juice, Avena sativa (oat) kernel flour, beeswax, cetyl alcohol, citric acid, glyceryl stearate, isopropyl myristate, methylparaben, PEG-40 stearate, polysorbate 60, propylene glycol, propylparaben, sodium citrate, sorbic acid, sorbitan stearate, stearyl alcohol, tocopheryl acetate, water

Warnings
*do not use in the eyes *for the treatment of diaper rash

Other information
Store at room temperature. Protect from freezing and excessive heat.

Sample Prescription Label

AJ's Pharmacy
444 Medicine Way
Blue Sky, NC 27599

Dr. E. Donoghue
(732) 775-5500

NO 0123456-78907
DATE 09/20/2009

Take one teaspoon by mouth three times daily for 10 days

Shake before using.

Sample OTC Label

Effective Relief of Itching from Inflammation and Rashes due to:
Eczema *Psoriasis *Seborrheic Dermatitis
Poison Ivy *Oak *Sumac *Insect Bites
Detergents *Soaps *Cosmetics *Jewelry

Aveeno
1% HYDROCORTISONE ANTI-ITCH CREAM

Drug Facts

Active ingredient
Hydrocortisone 1%

Purpose
Anti-Itch

Warnings
*provides temporary relief of the itching associated with minor skin irritations, inflammation, and rashes from:
*eczema *psoriasis *insect bites *seborrheic dermatitis *soaps *poison ivy *poison oak *poison sumac *jewelry *cosmetics *detergents
*other uses of this product should be only under the advice and supervision of a doctor

Use only as directed. Stop use and ask a doctor if
*symptoms last for more than 7 days *the condition gets worse *symptoms clear up and come back in a few days

Questions? 1-877-298-2525

Exp 10/200X

Adapted from © 2006 UNC-CH/MCH and NC DHHS/DCD
Sample Policy Activity
NCCCHCA Medication Administration Policy

Belief Statement

Best Practice:

• Families should check with the child’s physician to see if a dose schedule can be arranged that does not involve the hours the child is in the child care facility.

Intent Statement

This policy is intended to ensure safe administration of medication to children with chronic conditions, mild illnesses or special health needs for whom a plan has been made and the plan has been approved by the Director: Mr. Oscar Meier Weiner.

Background

Almost all children require medication at some point in time. Administration of medication poses a liability and an extra burden for staff, and having medication in the facility is a safety hazard.

Administration of medication requires clear, accurate instruction and knowledge of why a child needs the medicine. Child care providers need to be aware of what the child is receiving, when it is to be given, how to read the label directions in relation to the measured doses, frequency, expiration dates, and be aware of any side effects. This policy applies to all medication administration for any child within the facility.

Procedure/Practice

I. Written Authorization:

1. Medication will be administered only if the parent or legal guardian has provided written, signed and dated consent to include:
   • child’s first and last name
   • name of medication
   • time the medication should be given and how often
   • criteria for the administration of the medication
   • how much medication to give
   • manner in which the medication shall be administered (oral, topical, injection, etc.)
   • medical conditions or possible allergic reactions
   • length of time the authorization is valid, if less than six months

2. The length of time the consent is valid:
   a) Up to six months:
      1. A prescription medication shall be valid for the length of time the medication is prescribed to be taken up to six months.
      2. Prescription or over-the-counter medication, when needed, for chronic medical conditions and for allergic reactions.
   b) Up to 30 days:
      1. Other over-the-counter medications except as allowed in Items (c),(d),(e), or (f) below:
   c) Up to 12 months:
1. To apply over-the-counter, topical ointments, gels, lotions, creams, or powders such as sunscreen, diapering creams, baby lotion, baby powder, insect repellent or teething gel to a child, when needed.

d) Valid for as long as the child is enrolled:
   1. Standing authorization to administer an over-the-counter medication as directed by the North Carolina State Health Director or designee, when there is a public health emergency as identified by the North Carolina State Health Director or designee. This permission will include a statement that the authorization is valid until withdrawn by the parent/guardian in writing.

     e) At any time:
        1. A parent/guardian may withdraw his or her written authorization for the administration of medications at any time in writing.

f) Standing authorization: (option to omit for best practice)
   1. A written statement signed by the parent/guardian may give standing authorization for a one time weight appropriate dose of acetaminophen if the child has a fever and the parent/guardian can not be reached.

3. If any question arises concerning whether medication provided by the parent/guardian should be given, a physician’s note must accompany the medication.

4. Exception to Authorization:
   A caregiver may administer medication to a child without parental authorization in the event of an emergency medical condition when the child’s parent/guardian is unavailable. The medication must be administered with the authorization and in accordance with instructions from a bona fide medical care provider.

II. Prescription Medication:

Prescription medications such as antibiotics, seizure medications or others:

1. Must be administered only to the child for whom they were prescribed.

2. Must be in its original child resistant container labeled by the pharmacist to include:
   • child’s first and last name
   • name of medication
   • date prescription was filled
   • name of health professional who wrote the prescription
   • medication expiration date, storage information
   • instructions on administration: dosage amount, frequency, and specific indications for “as needed”. (An accompanying sheet with this written information is acceptable. It must bear the child’s name and be signed and dated by the physician.) See definitions section for more information.

3. Pharmaceutical samples must be stored in the manufacturer’s original packaging, must be labeled with the child’s name, and shall be accompanied by written instructions as for all prescriptions.

III. Over-the-Counter Medications:

Over-the-Counter (OTC) medications such as cough syrup, decongestant, acetaminophen, ibuprofen, topical antibiotic cream for abrasions, or medication for intestinal disorders:

1. Must be in the original container labeled by the parent or legal guardian with the child’s first and last names.

2. Must be accompanied by written instructions signed and dated by the parent or guardian specifying:
   • child’s first and last name
   • name of the medication
   • conditions for use
   • dose of the medication
   • how often the medication may be given
   • manner in which the ointments, repellents, lotions, creams, and powders shall be applied
   • any precautions to follow
   • length of time the authorization is valid
3. Administered as authorized with specific, legible written instructions by the parent or legal guardian not to exceed amounts and frequency of dosage specified by the manufacturer.
4. If manufacturer’s instructions include consultation with a physician for dose or administration instructions, written dosage instructions from a licensed physician or authorized health professional is required.

IV. Medication will not be given if it is:  
1. not in the original container  
2. beyond the date of expiration on the container  
3. without written authorization  
4. beyond expiration of the parental or guardian consent  
5. without the written instructions provided by the physician or other health professional legally authorized to prescribe medication  
6. in any manner not authorized by the child’s parent/guardian, physician or other health professional  
7. for non-medical reasons, such as to induce sleep  

V. Receipt, Storage and Disposal:  
1. All medications brought in to the center will be given to the Director for review and approval.  
2. Medications will be stored in a sturdy, child-resistant, locked container that is inaccessible to children and prevents spillage.  
3. Medications will be stored at the temperature recommended for that type of medication. It shall not be stored above food. A lock box can be kept in a designated refrigerator not accessible to children to hold medications.  
4. Emergency medication may be left unlocked so long as they are stored out of the reach of children at least 5 feet above the floor.  
5. Non-prescription diaper creams shall be stored out of reach of children at least 5 feet above the floor, but are not required to be in locked storage.  
6. Any medication remaining after the course of treatment is completed or authorization is withdrawn will be returned to the parent/guardian within 72 hours or it will be discarded. Contact your Child Care Health Consultant or Health Department for instructions on how to properly discard. If discarded, another staff will witness and sign to the fact it was discarded and how it was discarded.

VI. Training:  
1. Only staff persons who have documentation of medication administration training by a licensed health care professional will administer medication.  
2. A staff member trained in medication administration will be on site at all times when children are present.

VII. Documentation:  
1. A medication log will be maintained in the child’s file by the facility staff to record any time prescription or over-the-counter medication is administered by child care facility personnel.  
2. The child’s name, date, time, amount and type of medication given, and the name and signature of the person administering the medication shall be recorded for each administration.  
3. The log may be part of the medication permission slip or on a separate form developed by the provider which includes the required information.  
4. Only one medication shall be listed on each form.  
5. Spills, reactions, and refusal to take medication will be noted on this log.  
6. No documentation shall be required when over-the-counter, topical ointments, gels, lotions, creams, and powders — such as sunscreen, diapering creams, baby lotion, baby powder, topical teething products, or insect repellents — are applied to children.

VII. Medication Error:  
1. In the event of a medication error, the appropriate first aid or emergency action will be taken.
2. Director, parent/guardian, and as needed, the nurse or physician will be notified.
3. A medication error and an incident report will be prepared.

Applicable:
This policy applies to all staff, families, volunteers, and visitors who use the child care services at Laughing Lots Child Care.

Communication:
1. Staff: will review policy, and sign they have reviewed policy during orientation, yearly and if revisions are made.
2. Parent/Guardian: will be notified by letter and handbook and will sign for receipt.

References:
1 Caring for Our Children – Second Edition
2 NC Child Care Law GS 110.91 and NC Child Care Rule: 10A NCAC 09 .0803
3 NC GS 110-102.1A
4 Model Child Care Health Policies 3rd edition
5 NC Environmental rule: 15A NCAC 18A.2820(d)

Review/Approval:
This policy will be reviewed and approved by:

8/2/06
Owner/director

8/3/06
DCD Consultant

08/02/06
Child Care Health Consultant

8/2/06
Other as applicable

Effective Date: August 7, 2006

Annual Review Date: 08 07 2007

Definition:
11.2 As needed medications: A physician may state that a certain medication may be given for a recurring problem, emergency situation, or chronic condition. The instructions should include the child’s name; the name of the medication; the dose of the medication; how often the medication may be given; the conditions for use; and any precautions to follow. For example:
• A child may have sunscreen applied as needed to prevent sunburn;
• A child who wheezes with vigorous exercise may take one dose of asthma medicine before vigorous active (large muscle) play;
• A child with a known serious allergic reaction to a specific substance who develops symptoms after exposure to that substance may receive epinephrine from a staff member who has received training in how to use an auto-injection device prescribed for that child (e.g., EpiPen®).
### NC Policy Review: What is missing?

Instructions: Review a NC MA Policy. Put a check to see if the policy elements listed on this page are present in the policy.

<table>
<thead>
<tr>
<th>Title</th>
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<tbody>
<tr>
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<tr>
<td>Belief Statement</td>
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<td>Intent Statement</td>
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<td>Background</td>
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<td>Procedures</td>
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<td>Authorization</td>
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<td>Communication</td>
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</tr>
<tr>
<td>Effective Date</td>
</tr>
<tr>
<td>Review Date</td>
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</table>
Medication Administration Policy Checklist

- Title: A couple of words that describe the content of the policy plus a numerical code, if applicable.

- Belief Statement: A brief statement about why the center believes the policy is necessary. A facility may include policy options, best practice or NC law. (Example: XYZ Child Care believes all children have the right to safe medication administration practices in child care.)

- Intent Statement: An explanation of the purpose of the policy. (Example: This policy is intended to prevent errors in medication administration and provide child care providers with a plan in case of an emergency.)

- Background: A description of why the policy was developed. Not every policy will have a background statement.

- Procedure/Practice: Action steps necessary to accomplish what the policy recommends.
  - Written Authorization
  - Prescription Medication
  - Receipt
  - Disposal
  - Training/Who will give medication
  - Written/Telephone Instructions
  - Over-the-Counter Medication
  - Storage
  - Documentation
  - Medication Error

- Applicable: To whom does the policy apply? (Children, staff, families, etc)

- Communication: How are families/staff informed about the policy? (Parent handbook, newsletter, etc)

- References: What information was used to develop the policy or procedure? (Books, journal articles, Internet sources, etc)

- Review: Who reviews policies at the center? (Director, CCHC, legal advisor, board, policy council, etc.) Each of these people need a professional signature and date.

- Effective Date: When will the policy be put into effect?

- Review Date: How often will the center review the policy? (Every 6 months, every year, etc)
FLOOR PLAN ACTIVITY
Where to store medication

Identify where to store the following items:

- Prescription medication
- Over-the-counter medication
- Emergency medication
- Preventive substances (sunscreen, etc)

A locked box is available to you.
The cabinets are 6 feet.
The low shelves are 3 feet.
FLOOR PLAN ACTIVITY ANSWER KEY
Where to store medication

**Kitchen:**
- Locked box
- Locked box in cabinet for prescription or OTC medications
- Refrigerator with locked box for items needing refrigeration
- Cabinet over 5 feet for preventive and emergency medications

**Office:**
- Locked box or locked closet for all except emergency medications

**Classroom:**
- This area is less private and has more distractions so is not optimal
- Over 5 feet
- Locked box in high cabinets
- Locked closet
- High shelf over 5 feet for preventive and possibly for emergency medications
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

AJ's Pharmacy
444 Medicine Way
Blue Sky, NC 27599

Keep your family healthy for less

NO 0123456-78907

Dr. E. Donoghue
(732) 775-5500

DATE 09/20/2009

PH (800)333-6868

Nick Sample
123 Main Street
Anywhere, USA

Take one teaspoon by mouth
three times daily for 10 days

Shake before using.

Amoxicillin Suspension 250 mg/5 cc

MFG BIGCOMPANY

NO REFILLS - DR. AUTHORIZATION REQUIRED

USE BEFORE 06/2020
**Medication Administration Packet**

**Authorization to Give Medicine**

**PAGE 1—TO BE COMPLETED BY PARENT**

<table>
<thead>
<tr>
<th><strong>CHILD’S INFORMATION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Facility/School</strong></td>
<td>ABC Child Care Center</td>
</tr>
<tr>
<td><strong>Name of Child (First and Last)</strong></td>
<td>Nick Sample</td>
</tr>
<tr>
<td><strong>Name of Medicine</strong></td>
<td>Amoxicillin Suspension 250 mg/5 cc</td>
</tr>
<tr>
<td><strong>Reason medicine is needed during school hours</strong></td>
<td>Ear Infection</td>
</tr>
<tr>
<td><strong>Dose</strong></td>
<td>One teaspoon</td>
</tr>
<tr>
<td><strong>Route</strong></td>
<td>By mouth</td>
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<tr>
<td><strong>Time to give medicine</strong></td>
<td>Noon</td>
</tr>
<tr>
<td><strong>Additional instructions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date to start medicine</strong></td>
<td>0/0/20xx Monday</td>
</tr>
<tr>
<td><strong>Stop date</strong></td>
<td>X/1/20xX</td>
</tr>
<tr>
<td><strong>Known side effects of medicine</strong></td>
<td>Diarrhea</td>
</tr>
<tr>
<td><strong>Plan of management of side effects</strong></td>
<td>Rice cereal and yogurt to eat</td>
</tr>
<tr>
<td><strong>Child allergies</strong></td>
<td>None</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>PRESCRIBER’S INFORMATION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribing Health Professional’s Name</strong></td>
<td>Elaine Davoahue, mo</td>
</tr>
<tr>
<td><strong>Phone Number</strong></td>
<td>(732) 776-5600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PERMISSION TO GIVE MEDICINE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Parent or Guardian Signature</strong></td>
<td>Nicole Sample</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>123 Main Street, Anywhere, USA</td>
</tr>
<tr>
<td><strong>Home Phone Number</strong></td>
<td>123-4567</td>
</tr>
<tr>
<td><strong>Work Phone Number</strong></td>
<td>234-5678</td>
</tr>
<tr>
<td><strong>Cell Phone Number</strong></td>
<td>987-6543</td>
</tr>
</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td>(First)</td>
<td>Nick</td>
</tr>
<tr>
<td>Gender</td>
<td>☑ Male</td>
</tr>
<tr>
<td>Date of Birth</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

Work Telephone/Cell Phone Number: 234-567-8

Parent/Guardian Name: Michael Sample

Home Telephone Number: 123-456-7

Work Telephone/Cell Phone Number: 981-654-3

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:

Weight (must be taken within 30 days for WIC): 25 lbs

Height (must be taken within 30 days for WIC): 30 inches

Head Circumference (if <2 Years): 46 cm

Blood Pressure (if ≥3 Years):

IMMUNIZATIONS

[☑ Immunization Record Attached]

[☐ Date Next Immunization Due: At 2 years of age]

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries
- List medical conditions/ongoing surgical concerns:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Medications/Treatments
- List medications/treatments:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Limitations to Physical Activity
- List limitations/special considerations:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Special Equipment Needs
- List items necessary for daily activities:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Allergies/Sensitivities
- List allergies:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Special Diet/Vitamin & Mineral Supplements
- List dietary specifications:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Behavioral Issues/Mental Health Diagnosis
- List behavioral/mental health issues/concerns:
  - [☐ None]
  - [☐ Special Care Plan Attached]

Emergency Plans
- List emergency plan that might be needed and the signs/symptoms to watch for:
  - [☐ None]
  - [☐ Special Care Plan Attached]

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>12/20/02</td>
<td>11.35</td>
<td>Hearing</td>
<td></td>
<td>Passed</td>
</tr>
<tr>
<td>Lead: Capillary Venous</td>
<td>12/20/02</td>
<td>3</td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Developmental</td>
<td>12/20/02</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, MD

Signature/Date: Elaine Donoghue, MD

Health Care Provider Stamp:

CH-14 SEP 06 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 1/20xx

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
## Group Activity: Receiving Medication, Scenario 1

### Medication Administration Packet

**Authorization to Give Medicine**

**PAGE 1—TO BE COMPLETED BY PARENT**

<table>
<thead>
<tr>
<th>Child's Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Facility/School</strong></td>
</tr>
<tr>
<td><strong>Name of Child (First and Last)</strong></td>
</tr>
<tr>
<td><strong>Name of Medicine</strong></td>
</tr>
<tr>
<td><strong>Reason medicine is needed during school hours</strong></td>
</tr>
<tr>
<td><strong>Dose</strong></td>
</tr>
<tr>
<td><strong>Time to give medicine</strong></td>
</tr>
<tr>
<td><strong>Route</strong></td>
</tr>
<tr>
<td><strong>Date to start medicine</strong></td>
</tr>
<tr>
<td><strong>Stop date</strong></td>
</tr>
<tr>
<td><strong>Known side effects of medicine</strong></td>
</tr>
<tr>
<td><strong>Plan of management of side effects</strong></td>
</tr>
<tr>
<td><strong>Child allergies</strong></td>
</tr>
</tbody>
</table>

### Prescriber's Information

| Prescribing Health Professional's Name | Elaine Donovan, MD |
| Phone Number | (732) 775-5500 |

### 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.

| Parent or Guardian Name (Print) | Nick Sample |
| Parent or Guardian Signature |  
| Address | 123 Main St., Anywhere, USA |
| Home Phone Number | 123-456-78 |
| Work Phone Number | 234-567-89 |
| Cell Phone Number | 987-654-32 |

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 2

Maria is 3-years-old and has eczema. She needs hydrocortisone cream applied to her arms at noon time. This is an OTC medication with a brand name of Aveeno®. Aveeno also makes other non-medicated skin moisturizers as well, but the medication that is being requested is an OTC hydrocortisone cream. Maria has had this medication before.

- Switch roles from Scenario 1: Nick.

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

- Conclude the activity with the instructor posing “What if” questions like:
  - “What if the label with Maria’s name blocked the instructions?”
  - “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:
- Cream with instructions blocked by Maria’s name
- Incomplete Authorization to Give Medicine form
### Drug Facts

<table>
<thead>
<tr>
<th>Active ingredient</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocortisone 1%</td>
<td>Anti-itch</td>
</tr>
</tbody>
</table>

### Uses
- Provides temporary relief of the itching associated with minor skin irritations, inflammation, and rashes from:
  - Eczema
  - Psoriasis
  - Seborrheic Dermatitis
  - Poison Ivy
  - Oak
  - Sumac
  - Insect Bites
  - Detergents
  - Soaps
  - Cosmetics
  - Jewelry
- Other uses of this product should be only under the advice and supervision of a doctor.

### Warnings
- For external use only
- Do not use *in the eyes* *for the treatment of diaper rash*

### Directions
- Adults and children 2 years and older: apply to affected area not more than 3-4 times daily.
- Children under 2 years of age: do not use, ask a doctor.

### Inactive ingredients
- Aloe barbadensis leaf juice, Avena sativa (oat) kernel flour, beeswax, cetyl alcohol, citric acid, glyceryl stearate, isopropyl myristate, methylparaben, PEG-40 stearate, polysorbate 60, propylene glycol, propylparaben, sodium citrate, sorbic acid, sorbitan stearate, stearyl alcohol, tocopheryl acetate, water.

### Questions?
- 1-877-298-2525

### Exp
- 10/200X
**Group Activity: Receiving Medication, Scenario 2**

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**Medication Administration Packet**

**Authorization to Give Medicine**

**PAGE 1—TO BE COMPLETED BY PARENT**

<table>
<thead>
<tr>
<th>CHILD’S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Child Care Center</td>
</tr>
<tr>
<td>Name of Facility/School</td>
</tr>
<tr>
<td>Name of Child (First and Last)</td>
</tr>
<tr>
<td>Name of Medicine</td>
</tr>
<tr>
<td>Reason medicine is needed during school hours</td>
</tr>
<tr>
<td>Dose</td>
</tr>
<tr>
<td>Time to give medicine</td>
</tr>
<tr>
<td>Additional instructions</td>
</tr>
<tr>
<td>Date to start medicine</td>
</tr>
<tr>
<td>Known side effects of medicine</td>
</tr>
<tr>
<td>Plan of management of side effects</td>
</tr>
<tr>
<td>Child allergies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRESCRIBER’S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elaine Donoghue, MD</td>
</tr>
<tr>
<td>Prescribing Health Professional’s Name</td>
</tr>
<tr>
<td>(732) 776 - 5600</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERMISSION TO GIVE MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent or Guardian Name (Print)</th>
<th>Maria Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>123 City Road, Uptown USA</td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>987-16543</td>
</tr>
<tr>
<td>Work Phone Number</td>
<td>876-5432</td>
</tr>
<tr>
<td>Cell Phone Number</td>
<td>123-4567</td>
</tr>
</tbody>
</table>

---

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 2

UNIVERSAL CHILD HEALTH RECORD

SECTION I - TO BE COMPLETED BY PARENT(S)

<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test</td>
<td>Maria</td>
<td>☑ Female</td>
<td>1/1/2000</td>
</tr>
</tbody>
</table>

Does Child Have Health Insurance? Yes ☐ No ☑
If Yes, Name of Child's Health Insurance Carrier: BCBS

Parent/Guardian Name: Maria Test
Home Telephone Number: 987-6543
Work Telephone/Cell Phone Number: 876-5432

Parent/Guardian Name: Hector Test
Home Telephone Number: 987-6543
Work Telephone/Cell Phone Number: 123-4567

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: Maria Test

This form may be released to WIC.

☑ Yes ☐ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: ☑ Yes ☐ No

Abnormalities Noted:
- Weight (must be taken within 30 days for WIC): 35 lbs
- Height (must be taken within 30 days for WIC): 36 inches
- Head Circumference (if <2 Years):
- Blood Pressure (if ≥3 Years):

IMMUNIZATIONS

☒ Immunization Record Attached
☐ Date Next Immunization Due: At 4 years of age

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:

COCKTAIL OF ADEQUACY

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>X X 200x</td>
<td>11.5 131</td>
<td>Hearing</td>
<td>Birth</td>
<td>Pass</td>
</tr>
<tr>
<td>Lead: ☐ Capillary ☑ Venous</td>
<td>X X 200x</td>
<td>5 5</td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td>X X 200x</td>
<td>10 10</td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>X X 200x</td>
<td>Normal</td>
<td>Developmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>Scoliosis</td>
<td></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): Elia Loong

Signature/Date: Elia Loong MD

Distribution: Original: Child Care Provider  Copy: Parent/Guardian  Copy: Health Care Provider
Group Activity: Receiving Medication, Scenario 2

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

Name of child: Maria Test

Name of medicine: Hydrocortisone 1%

Date medicine was received: 1/1/200x

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
Group Activity: Receiving Medication, Scenario 2

Medication Administration Packet

Authorization to Give Medicine

PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

Name of Facility/School

Name of Child (First and Last)

Name of Medicine

Reason medicine is needed during school hours

Dose

Time to give medicine

Additional instructions

Date to start medicine

Stop date

Known side effects of medicine

Plan of management of side effects

Child allergies

PREScriber's INFORMATION

Prescribing Health Professional's Name

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.

Parent or Guardian Name (Print)

Parent or Guardian Signature

Address

Home Phone Number

Work Phone Number

Cell Phone Number

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