

Dear Parents:

As a licensed childcare facility, we are required to comply with legislation regarding the dispensing of medication. It is important that you are aware of the effects these regulations will have on you as a parent. Attached you will find the following 2 forms which need to be returned to school:

1. **Permission to Administer Over-the-Counter Topical Medications:**

This form must be completed by a parent in order for us to administer any over-the-counter topical medication. Please be aware that this form applies only to OTC Topical Medications, and is valid for 6 months.

2. **Medication Notification Agreement:**

Per regulations, we are required to document any instance when a child has been medicated or has received a treatment prior to coming to school.

Also attached you will find a **Written Medication Consent Form**. This form must be completed by a parent and licensed authorized prescriber in order for us to administer any prescription medication or over-the-counter medication (with the exception of OTC topical medications). This form must be updated every 6 months for all medication to be administered on an as-needed basis.

Finally, please be aware of the following regulations and procedures:

- All medication, along with the completed **Written Medication Consent Form** or **Permission Form** must be brought to the ECDP office by a parent.
- Medication will only be accepted in its original container. Over-the-counter medication must be labeled with the child's first and last name. prescription medication must contain the original pharmacy label with the child's name, medical provider's name, pharmacy name and telephone number, date prescription was filled, expiration date of the medication, dosage, how often to give the medication, and the date the medication should be discontinued or how many days the medication is to be given.
- Your child's medication (with the exception of OTC topical medications will be administered in the ECDP office by a staff member who has received the training required by law to dispense medication.
- An individual health care plan will need to be developed for any child with special health care needs.

Please do not hesitate to contact us with any questions. Thank you in advance for your cooperation and compliance with these regulations.

## OVER-THE-COUNTER MEDICATION CHECKLIST

Please check off any over-the-counter topical medications that you may choose to bring for ECDP staff to administer for your child. If your child must use a specific brand of any of the products listed, please indicate the brand name of the product next to the category. If any brand is acceptable just check Yes or No beside the product.

Child's Name \_\_\_\_\_

Approval	Product	Does your child need to use a specific brand?	What is that brand? <i>These items must be supplied by the parent.</i>
Parent's Initial _____	Sunscreen	___ Yes ___ No	
Parent's Initial _____	Insect Repellent	___ Yes ___ No	
Parent's Initial _____	Diaper Cream	___ Yes ___ No	
Parent's Initial _____	Vaseline	___ Yes ___ No	
Parent's Initial _____	Antibacterial Hand Wipes	___ Yes ___ No	

Please check any of the following for which you give permission for ECDP to administer to your child in the event of a cut, scrape, or bite:

Approval	Product	Does your child need to use a specific brand?	What is that brand? <i>These items must be supplied by the parent.</i>
Parent's Initial _____	First Aid Cream/Spray	___ Yes ___ No	
Parent's Initial _____	Hydrogen Peroxide	___ Yes ___ No	
Parent's Initial _____	After Bite	___ Yes ___ No	
Parent's Initial _____	Calamine Lotion	___ Yes ___ No	
Parent's Initial _____	Bandage	___ Yes ___ No	

## OVER-THE-COUNTER MEDICATION PERMISSION

I, \_\_\_\_\_ give permission to the Early Childhood Development Program to apply topical over-the-counter medications to my child, \_\_\_\_\_, according to label directions. I understand that the stocked brand may be used unless I have indicated a specific brand above.

This permission will be in effect from \_\_\_\_\_ to \_\_\_\_\_.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**THIS FORM MUST BE UPDATED EVERY 6 MONTHS.**

## AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical, dental, health, or hospital services, you as the parent must give permission. It's the law.

What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when you are away from home. To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

This is a legal document. With it, you may appoint relatives, friends, teachers, clergy, neighbors – anyone who is over 18 years of age – to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Fill out this form carefully. Have your signature witnessed by an adult differet from the person you are making responsible for your children. After you complete this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person – physician, dentist or hospital representative.

Names of Minors	Birthdates	Identify Allergies or Special Conditions

I/We, being the parents(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

**The Jewish Community Center**  
**Early Childhood Staff**  
 5655 Thompson Rd., Dewitt, NY 13214  
 315-445-2360 ext. 120

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from the dates of:

September 8, 2009 through June 23, 2010

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent Signature	Date	Parent Signature	Date
Address		Address	
Witness Signature	Date	Witness Signature	Date
Address		Address	

## HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S):

Insurance Company or Government Program	ID or Contract Number
---	-----------------------

## FAMILY PHYSICIANS

Name	Phone Number
Name	Phone Number

- The parent must ensure that all areas of the first page are filled out.
- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication the child is on. Multiple medications cannot be listed.
- Do not use this form to document administration of one-day only medication. Use the Verbal Medication Consent Form and Log of Administration.

## INFORMATION

Child's First & Last Name		Date of Birth
Child's Known Allergies		
Provider/Facility Name <b>Early Childhood Development Program</b>	Facility ID Number <b>000400036DCC</b>	Facility Phone Number <b>315-445-2040 Ext. 120</b>

## AUTHORIZED PRESCRIBER TO COMPLETE *(except for over-the-counter topical ointments and sunscreen which parents must complete)*

Licensed Authorized Prescriber's Name	Licensed Authorized Prescriber's Phone Number
Name of Medication (including strength if applicable)	Amount/dosage to be Given:
Date to be Discontinued or Length of Time in Days to be Given (up to 6 months)	Time(s) to be Administered (for non PRN medication)
Refrigeration Required <input type="checkbox"/> Yes <input type="checkbox"/> No	Route of Administration
Reason for Taking Medication (unless confidential by law)	
Possible Side Effects	
What Action to Take if Side Effects are Noted	
Special Instructions (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered)	

## MEDICATION CONSENT/AUTHORIZATION

I, \_\_\_\_\_ authorize the **Early Childhood Development Program** to administer the medication listed above to  
 \_\_\_\_\_  
 Parent/Legal Guardian

\_\_\_\_\_  
 Child's Name

## REQUIRED SIGNATURES

Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date
Name of Provider Who Received This Statement	Provider Signature	Date Received From Parent

## SIGNATURE REQUIRED FOR ALL MEDICATION INSTRUCTIONS *(except over-the-counter topical ointments and sunscreen lotion)*

Licensed Authorized Prescriber's Name (print)	Licensed Authorized Prescriber's Signature	Date
---	--	------

## MEDICATION DISCONTINUATION AUTHORIZATION *(complete only if discontinue date is PRIOR to date listed above)*

I, \_\_\_\_\_ request that the medication listed above be discontinued effective \_\_\_\_\_.  
 \_\_\_\_\_  
 Parent/Legal Guardian Medication Discontinue Date

Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date
---------------------------------	--------------------------------------	------



**MEDICATION NOTIFICATION AGREEMENT**

I, \_\_\_\_\_, agree to notify my child care provider each time my child has been medicated or receives a treatment before coming to the Early Childhood Development Program. I will inform the Early Childhood Development Program of the name of the medication, the time it was given, and any side effects they should be aware of.

Child's Name

Parent Signature

Date