Little Acorn Patch, Ltd.

5801 Castlewellan Drive
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January 30, 2012

Dear LAP Parents:

Please review LAP's policy for distributing medications and lotions. A form must be filled out for each medication/lotion given and turned into the Front Desk. All medication(s) and lotion(s) should be in the original package with labels (no doctor office samples). LAP administers medication at the following times 11:00am-12:00pm and 3:00pm-4:00pm.

If you have any questions, please see one of the administrative staff members.

Thank you,
LAP Administration

Encl:
MAT Medication Permission Requirements (over)
Medical Release Form (copies at LAP's Front Desk)

Handout 2.3

PERMISSION REQUIREMENTS
SHORT-TERM MEDICATION ADMINISTRATION

The following table indicates the permission needed to administer a medication to any child in your care for <u>ten days or less</u>. WORKING DAYS

Medication Type	Medication Route	Type of Permission Needed (written)	
		Parent Permission	Health Care Provider Instructions
Over-the-counter Diaper Creams Chap stick Hand Lotion Vaseline	Topical	Written	*None needed**
	Oral	Written	*None needed**
	Inhaled/Nasal	Written	*None needed**
	Patches	Written	*None needed**
	Eye	Written	*None needed**
	Ear	Written	*None needed**
Prescription	Topical	Written	*None needed**
	Oral	Written	*None needed**
	Inhaled/Nasal	Written	*None needed**
	Patches	Written	*None needed**
	Eye	Written	*None needed**
	Ear	Written	*None needed**
	Nebulizer	Written	Written
	EpiPen® Injection	Written	Written

*The parent's instructions for administration must be consistent with any directions for use noted on the original container, including but not limited to precautions related to age and special health conditions. **If the instructions are not consistent, *written* instructions from the child's health care provider are <u>required</u>.**

NOTE: All permissions must be renewed or discontinued after ten (10) work days.

Handout 2.3

PERMISSION REQUIREMENTS
LONG-TERM MEDICATION ADMINISTRATION

The following table indicates the permission needed to administer a long-term medication to any child in your care. Long-term medication is defined as any medication that is authorized by the parent and/or health care provider to be administered or possibly administered for **<u>more than ten (10)</u>** days.

Medication Type	Medication Route	Type of Permission Needed (written)	
		Parent Permission	Health Care Provider Instructions
Over-the-counter	Topical	Written	*None needed**
	Oral	Written	Written
	Inhaled/Nasal	Written	Written
	Patches	Written	Written
	Eye	Written	Written
	Ear	Written	Written
Prescription	Topical	Written	Written
	Oral	Written	Written
	Inhaled/Nasal	Written	Written
	Patches	Written	Written
	Eye	Written	Written
	Ear	Written	Written
	Nebulizer	Written	Written
	EpiPen® Injection	Written	Written

*For over-the-counter topical medication where instructions from the child's health care provider are not required, the parent's instructions for administration must be consistent with any directions for use noted on the original container, including but not limited to precautions related to age and special health conditions. **If the instructions are not consistent, written instructions from the child's health care provider are <u>required</u>.**

NOTE: Long-term permissions must be updated at least every six months.

MAT Handout 2.4

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment, or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician"; the parent completes #19 through #23.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered:____________________

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) ____________________

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for a complete list of possible side effects

AND/OR

8B: Additional side effects:____________________

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe):____________________

10A. Special instructions:□ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) ____________________

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (date cannot exceed 6 months from the date authorized or this order will not be valid):

16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:
Required for Long-Term medications or when dosage directions state "consult a physician".

This is a double-sided form

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) ☐Yes ☐N/A ☐No
Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):____________

20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to ______________________________.
(child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:

23. Parent or legal guardian's signature:

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

24. Provider/Facility name:	25. Facility telephone number:	26. (leave blank)
Little Acorn Patch	703-822-0803	

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.

28. Authorized child care provider's name (please print):	29. Date received from parent:

30. Authorized child care provider's signature:

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on ______________________. Once the medication has been discontinued, I understand that if my child
(date)
requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. ______________________________

34. Licensed Authorized Prescriber's Signature:

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.
DATE:__________________
By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature: