

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S INFORMATION

Name of Facility/School ABC Child Care Center 6/1/XX
Today's Date
Name of Child (First and Last) Nick Sample 5/15/XX
Date of Birth
Name of Medicine Amoxicillin Suspension 250 mg/5cc
Reason medicine is needed during school hours ear infection
Dose One teaspoon (250 mg) Route by mouth
Time to give medicine Noon
Additional instructions _____
Date to start medicine 6/1/XX Stop date 6/11/XX
Known side effects of medicine diarrhea
Plan of management of side effects rice cereal and yogurt to eat
Child allergies none known

PRESCRIBER'S INFORMATION

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

PERMISSION TO GIVE MEDICINE

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

Nicole Sample
Parent or Guardian Name (Print)
Nicole Sample
Parent or Guardian Signature
123 Main St Anywhere USA
Address
123-4567 234-5678 987-6543
Home Phone Number Work Phone Number Cell Phone Number

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Nick Sample
Name of medicine Amoxicillin 250mg/5cc
Date medicine was received 6/1/11 Weight 25 lbs

Safety Check

- ☐ 1. Child-resistant container.
- ☐ 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 Nick Sample Weight of child 25 lbs

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

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

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		



Preparing to Give Medication

This is a checklist to use at your child care facility/school to make sure that your program is ready to give medication.

1. Paperwork

- ☐ Parent authorization to give medications is signed.
- ☐ Health care professional authorization or instructions are on file.
- ☐ Child Health Record is on file.

2. Medication checked when received

- ☐ Properly labeled.
- ☐ Proper container.
- ☐ Stored correctly.
- ☐ Instructions are clear.
- ☐ Disposal plan is developed.

3. Administering medication

- ☐ Area is clean and quiet.
- ☐ Staff is trained.
- ☐ Hands are washed.
- ☐ The 5 rights are followed—right child, medication, dose, time, and route.
- ☐ Child is observed for side effects.

4. Documentation

- ☐ Medication log is completed fully and in ink.

Documents in Appendix AA adopted 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, American Academy of Pediatrics, Connecticut Department of Public Health, Healthy Child Care Pennsylvania and Healthy Child Care Colorado, 2011.

Annual Asthma Action Plan

FOR BUSIE WILSON BIRTHDATE 2/12/XX YEAR PLAN 20XX-20XX

How to use this plan:

1. Fill out this form with your provider—and review it at least once a year.
2. Keep a copy with you at all times. If this form is for your child, make sure your child care provider, school nurse, sports coaches and others also have copies.
3. Use the colors and guidelines below to know when your (or your child's) asthma is under control, when it's getting worse, when it's an emergency—and what to do.

Asthma triggers (List the things that make your asthma worse):

mold
cigarette smoke
viral infections



IF YOU ARE:

YOU NEED TO:

DOING WELL

You're doing all of these:

- Breathing well with no coughing or wheezing
- Working and playing normally
- Sleeping through the night
- Had an annual flu shot

KEEP CONTROLLING YOUR ASTHMA

Step 1: Avoid asthma triggers. See back for more info.

Step 2: Take these medicines everyday, or as prescribed by your provider (and talk to your provider about using a spacer):

Keep albuterol MDI spacer 90 mcg available for use @ childcare preschool

GETTING WORSE

You have any of these:

- Any signs of a cold
- A cough (especially if it wakes you up at night)
- A mild wheeze
- A tight feeling in your chest
- Contact with an asthma trigger

TAKE ACTION TO HELP PREVENT AN EMERGENCY

Step 1: Slow down. Stop exercising or sit out from gym class or sports until feeling better.

Step 2: Keep taking your daily medicines and add these "rescue" or "relief" medicines:

Take albuterol MDI with spacer - 2 puffs for mild wheeze, tight chest, first signs of cold/cough.

Step 3: Call your provider if your symptoms don't get better within 24 hours (1 day). **If symptoms get worse, you may be having an asthma emergency. Follow the directions in the Red Zone.**

HAVING AN EMERGENCY

You have any of these:

- Hard and fast breathing
- Grey or bluish lips or nails
- Ribs showing or nose opening wide
- Trouble talking or walking

Or if your asthma medicine is not helping to ease your symptoms

GET HELP NOW

Step 1: Take these medicines right away:

Albuterol MDI with spacer - 2 puffs one minute apart. Take immediately for these signs of asthma.

Step 2: Call your provider, get to an emergency room, or call 911 now. DO NOT WAIT. ★

Dr. J. Jones

PROVIDER'S NAME

802-651-7564

PROVIDER'S PHONE #

Jane Wilson (mom) 734-5138

EMERGENCY CONTACT'S NAME

Robert Wilson (dad) 734-5139

EMERGENCY CONTACT'S PHONE #

cell

FOR YOU (THE PATIENT OR PARENT) TO FILL OUT:

Please check below to allow other caregivers or your school nurse to talk with the provider.

- ☒ I give permission to staff - Happy Days CC Ctr to communicate with the provider and help with managing my (or my child's) asthma.

If this form is for your child, please check one of these:

- ☒ I give permission to staff - Happy Days CC Ctr to give the medicines listed on this plan to my child.

—OR—

- ☐ My child is allowed to carry and take their own medicines.

Jane Wilson

YOUR SIGNATURE

mother
YOUR RELATIONSHIP TO THE PATIENT

6/15/XX
DATE SIGNED

FOR YOUR PROVIDER TO FILL OUT:

This patient's asthma is: (ex: severe, moderate, mild, exercise-induced, etc.)

mild persistent

This patient (please check one):

- ☐ Understands how to use their asthma medicines and can take their medicine/inhaler as needed
- ☐ Needs to notify the school nurse after using their medicine/inhaler
- ☒ Needs help to use their medicine/inhaler

This plan was reviewed by:

- ☐ I have reviewed this plan, the signs and symptoms of asthma and all prescribed medicines with the patient.
- ☒ The medications listed on this plan may be administered to the patient.

J Jones MD
PROVIDER'S SIGNATURE

6/15/XX
DATE REVIEWED

BREATHE DEEP.
LIVE BETTER.

Take on asthma
and take back your life.

VERMONT
DEPARTMENT OF HEALTH

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN



Child's name: Jose Cosmo Date of plan: 7-1-XX

Date of birth: 7/28/14 Age 2⁺ Weight: 25 kg lbs

Child has allergy to peanuts

Child has asthma. ☒ Yes ☐ No (If yes, higher chance severe reaction)
 Child has had anaphylaxis. ☒ Yes ☐ No
 Child may carry medicine. ☐ Yes ☒ No
 Child may give him/herself medicine. ☐ Yes ☒ No (If child refuses/is unable to self-treat, an adult must give medicine)



IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): peanuts. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
 - Ask for ambulance with epinephrine.
 - Tell rescue squad when epinephrine was given.
3. Stay with child and:
 - Call parents and child's doctor.
 - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
 - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
 - Antihistamine
 - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child**. Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): Epi Pen Jr Dose: ☒ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)

Antihistamine, by mouth (type and dose): Benadryl 12.5 mg po

Other (for example, inhaler/bronchodilator if child has asthma): Allice Cosmo

Parent/Guardian Authorization Signature 7-1-XX

Date

Physician/HCP Authorization Signature 7-1-XX

Date

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FIGURE 1

AAP Allergy and Anaphylaxis plan.

Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature _____

Adapted with permission from Healthy Child Care Colorado.