

Requirements for Inhaled Medicine at BlueSkies

All of us at BlueSkies for Children want to be certain that children receiving medication while they are at the center are kept safe. In addition, as a licensed child care center BlueSkies must follow multiple regulations concerning medication. We understand that it almost always requires at least one more trip to the pediatrician in order to complete this paperwork, but we CANNOT administer an inhaled medication without having every piece complete, so please follow instructions carefully.



These are the papers in the packet, and what you need to do with them:

1. The “**Parent Consent for Administration of Medications and Medication Chart**” form – you must complete this.
2. The “**Nebulizer Care Consent/Verification**” form must be completed for each teacher that you train to use the inhaler or nebulizer. You should arrange a time with the Head Teacher when key teachers can be out of the program for you to give them specific training in the correct usage, handling, and storage of the inhaler or nebulizer for your child. (Tip: Fill out the form with everything except for the teacher’s names, then we will be happy to make multiple copies for you so you only have to enter the names as you train staff members.) Only those teachers who have been trained by you can administer the inhaled medication.
3. The “**Physician’s Instruction and Record**” form must be completed by your child’s physician before any staff member can administer these medications.

When you bring the device in to your child’s classroom, please hand it directly to the Head Teacher with all the required paperwork so that it can be properly stored.

Attached:

Parent Consent for Administration of Medications and Medication Chart

Nebulizer Care Consent/Verification

Physician’s Instruction and Record

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

Note: Regulation Section 101221 requires the following information be on file.

CHILD CARE CENTER NAME:	LICENSE NUMBER:	DATE:
Hedco Infant Toddler Center - BlueSkies for Children	010213219	_____
Ellen Sherwood Nursery School – BlueSkies for Children	010209844	_____

INSTRUCTIONS TO THE PARENT

1. Shaded portions of this form must be fully and accurately completed or no medication can be administered. Written consent must be provided from the parent, permitting staff of BlueSkies for Children to administer medications to the child. Instructions must conform with the prescription label or product label directions.
2. Instructions for more than one day require daily completion of the column "Time of last dose by parent."
3. All prescription and nonprescription medications shall be maintained with the child's name, shall be dated, and shall be currently prescribed.
4. Prescription and nonprescription medications shall be administered in accordance with the label directions.
5. Prescription and nonprescription medications must be stored in the original bottles with unaltered labels. Medications requiring refrigeration must be properly stored.
6. Other than acetaminophen or ibuprofen, the staff of BlueSkies for Children will administer only medicine currently prescribed by a doctor. If the pediatrician directs you to give your child an over-the-counter medication, ask the doctor to provide us with a written prescription including the child's name, the name of the medication, the time and amount of correct dosage, and the way the dose is to be administered.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME—THIS MUST MATCH THE NAME ON CONTAINER	DOSAGE
<p>I authorize childcare personnel to assist in the administration of medications described above to the child named above for the following medical condition(s):</p> <p>_____</p>	
<p>From _____ to _____ at _____ daily while in attendance.</p> <p style="text-align: center;">BEGINNING DATE ENDING DATE TIME OF DAY</p>	
PARENT'S SIGNATURE	PHONE NUMBER TODAY
DATE	

The "Five Rights" of administering medication:

1. Right person
2. Right time and frequency of administration
3. Right drug
4. Right dose
5. Right route of administration

MEDICATION CHART

Staff Documentation of Medicine Administration

DATE	TIME OF LAST DOSE	TIME OF DOSE GIVEN BY STAFF	STAFF SIGNATURE: I have followed the Five Rights in administering this medication to this child.

Upon completion, any remaining medication has been returned to the parent and this form filed in child's office file.

HEAD TEACHER'S SIGNATURE	DATE
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**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

PHYSICIANS INSTRUCTIONS AND RECORD FORM

FOR INHALER OR NEBULIZER CARE

A new form must be completed if there are any changes in dosage or frequency of treatments

Child's name: _____ Date of Birth: _____

TO BE COMPLETED BY PEDIATRICIAN:

Physician: _____ Date This Form Completed: _____

Address: _____ Telephone: _____

Physician's Signature: _____

Name of Inhaled Medication: _____

This medication is to be administered by: (Check **ONE**) Nebulizer Inhaler

Specific indications (such as symptoms) for administering the medication in accordance with the prescription: _____

Potential side effects and expected response: _____

Dosage: _____

How often is the treatment to be given?: _____

Actions to be taken in the event of side effects or incomplete treatment response. This includes actions to be taken in an emergency: _____

Instructions for proper storage of the medication: _____

Caregivers: Write the date and time treatment was given and sign with your complete signature in the appropriate boxes below.

Date	Time	Signature	Date	Time	Signature