Written Medication Consent Form

Child's First and Last Name_______________________________DOB________________Weight__________

Child's Known Allergies____

Medication Name and Strength *(i.e. Baby Orajel, Benzocaine 7.5%)*__________________________________

Medication Expiration Date____________________________Amount/Dosage to be Given____________________

Frequency to be Administered *(i.e. every four hours)*____

OR

Times to be Administered *(i.e. 12:30 p.m., 4:30 p.m.)*____

If "as needed", list all potential *observable and measurable* symptoms that necessitate administration *(i.e. fever over 101)*________________

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Route of Administration *(i.e. oral, inhaled, topical, medicated patch, eye, ear, Epinephrine using an auto-injector)*____________________

Date Through Which Authorization is Effective____

**Date may not exceed 10 days with parent authorization or 6 months with prescriber authorization or this form will be invalid.*

Reason Child is Taking the Medication *(Unless Confidential by Law)*__________________________________

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A package insert or pharmacy printout with a complete list of possible side effects or special instructions must be supplied.

To be Checked by a Director When Received [ ]

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

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What action should we take if side effects are noted? [ ] Contact Parent [ ] Contact Prescriber at Phone Number Provided Below

[ ] Other____

____

Are the instructions on this form a change in dose, time, or frequency from an active *prescription* medication authorization that we have on file?

[ ] No [ ] Yes If yes, we must have the prescriber's signature in order to authorize the administration of the new dose, time, or frequency without the updated prescription label.

Licensed Authorized Prescriber's Signature____

Date by Which you Expect the Pharmacy to Fill the Updated Order______________________________

Please see reverse side.

Please note that BeanTree Learning cannot administer the first dose of any medication. By signing below, you indicate that your child has received this medication before and no side effects were noted.

Parent/Guardian Name *(Please Print)*______________________________

Parent/Guardian Signature______________________________Today's Date______________

For long-term medications authorized up to six months or when the dosage directions state "Consult a Physician," the Prescriber must sign below:

Prescriber's Name______________________________Prescriber's Phone Number______________

Prescriber's Signature______________________________

Does the above named child have a chronic physical, developmental, behavioral or emotional condition related to this medicine and 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 yes, the Licensed Authorized Prescriber must describe any additional training, procedures, or competencies that BeanTree Learning will need to care for your child and sign below.

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Prescriber's Signature______________________________

To Discontinue the Medication Before the Date Indicated Above:

I request that the medication indicated on this consent form be discontinued on (date)______________

Parent/Guardian Signature______________________________

BeanTree Learning Use Only

Campus: *Ashburn* *Westfields* *Phone Number:* *571.223.3110* *703.961.8222*

I have verified that this form is complete. My signature indicates that all information needed to give this medication has been provided.

*Director Name (Please Print)*______________________________*Date Form Received*______________

*Director Signature*______________________________