



**Office of Children  
and Family Services**

# **Medication Administration Training**

**Participant Materials**

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**New York State Office of Children and Family Services  
Division of Administration  
Bureau of Training and Development**

**AND**

**Professional Development Program  
Rockefeller College  
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***Acknowledgement***

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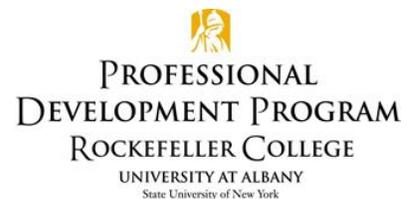
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**Office of Children  
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# Medication Administration Training (MAT) Participant Materials

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# Medication Administration Training (MAT) Resource Materials



The Medication Administration Training (MAT) course is approved by the Office of Children and Family Services (OCFS) and is designed to teach you best practice techniques for giving medication and to help you understand OCFS regulations about giving medication.

## **Regulations**

Regulations create the basic structure for the way child day care programs operate. They establish minimum standards for the quality of each program. As a child day care provider, you are responsible for knowing what is required by law and regulation. This course covers OCFS regulations about giving medication in your program.

Your MAT Trainer has a copy of the regulations available throughout this training. You should always have the most current version of the OCFS regulations at your program. Periodically check the OCFS website ([www.ocfs.ny.gov](http://www.ocfs.ny.gov)) for any changes.

## **Handouts**

There is a lot of information covered in the MAT course, both on video and in your handouts. You do not need to memorize the information in the training. The information provided on the video is also in your handouts. These handouts are yours to keep and you can use them throughout the training and in your program.

Handouts are sometimes updated with new information. The most current version of all of the MAT handouts is available at [www.ecetp.pdp.albany.edu](http://www.ecetp.pdp.albany.edu). The handouts have a date printed on the bottom of the page. The website will also have the date the handout was last updated. You should check the website on a regular basis for updates.

## **OCFS Forms**

Your MAT handouts include forms approved by OCFS. The MAT course uses the most current version of the forms approved by OCFS. You should periodically check the OCFS website ([www.ocfs.ny.gov](http://www.ocfs.ny.gov)) for the most current version or if you want an electronic version of the form(s).

## **Health Care Plans**

Your MAT Trainer has copies of each modality's health care plan template approved by OCFS. Your program must have a health care plan approved by OCFS. You should know what is written in your program's health care plan and follow the policies and procedures it contains.



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# Medication Administration Training (MAT) Overview



## ***Giving Medication in a Child Care Program***

The following are *not* considered medication and may be given with the written permission of the parent:

- Sunscreen
- Topically applied insect repellent
- Over-the-counter topical ointments (This includes ointments, creams, gels and lotions.)

However, if the package directions indicate to consult a doctor, you need written instruction from the child's health care provider before you can give it.

If the child needs medication other than what is listed above, you need to be approved to give medication. Part of the approval process is getting a Medication Administration Training (MAT) certificate.

## ***About the MAT Course***

- The MAT course trains child day care providers to safely give medication to children in a child care setting. It's approved by the New York State Office of Children and Family Services (OCFS).
- In this course, you'll learn seven ways to give medication:
  - ♦ On the skin (topically)
  - ♦ By mouth (orally; includes topically applied in the mouth)
  - ♦ Inhaled (the child breathes it in through his nose or mouth)
  - ♦ By using medicated patches
  - ♦ By putting it in the ear
  - ♦ By putting it in the eye
  - ♦ By using an auto-injector, like an EpiPen®, to give a shot of epinephrine
- You must pass a written test and the skills demonstrations to get a MAT certificate at the end of the course.

## ***To pass the course you must be able to:***

- Read and understand the information that comes with the medication in the language in which it is written. This includes medication labels, inserts and print-outs from the pharmacy.
- Read and understand the instructions from the parent and health care provider.
- Read and understand the parental permission forms.
- Write down that you have given the medication.
- Read, understand and be able to follow step-by-step instructions for the safe administration of medication.

### **Testing**

You will be tested on the information included in the MAT handouts and video only. You can use all of the MAT handouts when you take the test.

#### **Written Test**

- The test is 60 multiple-choice questions.
- You must get an 80% or above to pass the test.
- If you don't pass the written test on your first try, you can take another test with different questions. If you don't pass the test on your second try, you will need to complete the full MAT course again.

#### **Skills Demonstrations**

You must show a trainer that you can:

- Match the **Five Rights** of safe medication administration. You can read about the **Five Rights** on Handout 2.1.
- Safely give medication by one of the routes listed here:
  - ♦ Orally (by mouth)
  - ♦ Topically (on the skin)
  - ♦ Inhaled into the mouth or nose
  - ♦ In the eye
  - ♦ In the ear
  - ♦ By applying a medicated patch

You will be tested on only one route, but you must be prepared to give medication by any route listed above, since you will not know until the testing time which route you'll be tested on. There is an example of this on the video to help you get ready.

- Correctly measure liquid medication using:
  - ♦ a medicine cup;
  - ♦ a dosing spoon; or
  - ♦ an oral medication syringe.
- Correctly administer epinephrine using an auto-injector.

An approved MAT trainer will watch you complete each of these skills. If you don't pass on your first try, you can try again. You may be tested on the same route again or on a different route.

If you don't pass on your second try, you must take the course again.

#### **Individuals Who Are NOT Required to Attend MAT Training**

A person who can produce a valid New York State license as a physician, physician assistant, registered nurse, nurse practitioner, licensed practical nurse or advanced emergency medical technician will not be required to attend MAT training in order to administer medication in a day care program.

Documentation establishing the person's credentials in one of the above fields will be required and a copy of the documentation must be included with the Health Care Plan.

## Glossary



Use this glossary of selected words and phrases to help you to understand how they are used in the MAT course.

<b>abbreviation</b>	Short form or symbol used in place of complete word.
<b>acronym</b>	A word formed from the first letter(s) of each part of a compound term. (For example, MAT= <b>M</b> edication <b>A</b> dministration <b>T</b> raining.)
<b>active ingredient</b>	The main component of the medication that produces the medication's desired effect.
<b>acute illness</b>	Sickness that begins quickly and lasts only a short time. Some examples are ear infections and common colds.
<b>administration</b>	The act of giving.
<b>adverse effect</b>	Unexpected reaction of a medication that can be potentially harmful.
<b>allergic reaction</b>	A potentially harmful immune response to a foreign substance, including medication. Allergic reactions occur when the immune system overreacts to a substance called an allergen. These reactions do not always occur the first time the child comes in contact with the allergen and may get worse with each exposure.
<b>anaphylaxis</b>	A severe and potentially life-threatening sudden allergic reaction typically characterized by hives, swelling, shortness of breath and requiring immediate treatment. See Handout 9.2.
<b>Americans with Disabilities Act of 1990 (ADA)</b>	A law prohibiting discrimination on the basis of disability. See <a href="http://www.ada.gov">www.ada.gov</a> .
<b>asthma</b>	A chronic condition characterized by severe difficulty breathing caused by a spasm of the bronchial tubes or by swelling of mucous membranes caused by a response to a trigger and/or an allergen. See Handout 8.1.
<b>as needed medication</b>	Medication given to treat specific symptoms at non-specific times, often to relieve or control symptoms that may recur from a known condition. See "PRN" in this glossary.
<b>auto-injector</b>	Device for delivering an injection by an automatic system. See "epinephrine" in this glossary.

<b>brand name</b>	A name given to the medicine by the pharmaceutical company that created it. The name is followed by the symbol ®, which indicates that the name is a registered trademark.
<b>children with special health care needs</b>	Children with a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more that requires health and related services of a type or amount beyond that required by children generally. See Handout 10.4 and NYS Day Care Regulation 413.2(am).
<b>chronic illness</b>	Sickness or disease that is of long duration. It cannot be cured and will not go away. Some examples are asthma and diabetes.
<b>controlled substance</b>	Any substance the federal government has classified as having a high risk for misuse. Rules for prescribing and storing these substances are made by the federal government. A list of controlled substances can be obtained from the Drug Enforcement Administration. Some examples are Ritalin® and codeine.
<b>consanguinity</b>	A close relation or connection. A relative within the third degree of consanguinity of the parent or step-parent includes: the grandparents of the child; the great-grandparents of the child; the great-great-grandparents of the child; the aunts and uncles of the child, including the spouses of the aunts and uncles; the great-aunts and great-uncles of the child, including the spouses of the great-aunts and great-uncles; the siblings of the child; and the first cousins of the child, including the spouses of the cousins.
<b>contaminated</b>	Any substance or material that was exposed to body fluids, blood or airborne infectious materials. See Handout 6.2.
<b>CPR</b>	An acronym for <b>C</b> ardio- <b>P</b> ulmonary <b>R</b> esuscitation.
<b>curvature</b>	The bending of a line or surface. For this training, the term applies to the slope or curve seen when looking at the measurement of a liquid medication at eye level. The lowest point of the curvature is the point for measuring the correct amount of the medication ordered. See Handout 7.4.
<b>demonstration</b>	To perform physically or act out the steps to show understanding of safe medication principles. See Module 7.
<b>desired effect</b>	The beneficial and sought-after effect of the medication.
<b>disposal</b>	Discarding medication that is expired, damaged or no longer needed. See Handout 4.7.

<b>epinephrine</b>	A medication used to quickly relieve severe allergic reactions (anaphylaxis) until more medical care is available. This must be given by injection. See Module 9.
<b>expired medication</b>	Medication that can no longer be guaranteed as safe and effective, since either chemical breakdown or contamination may have occurred by the expiration date. A medication label may indicate “discard after” a specific date on the label. If the medication package gives an expiration date with a month and year only, the medication is good until the last day of the month.
<b><i>Five Rights</i></b>	The five pieces of information necessary to administer medication correctly. The <b><i>Five Rights</i></b> include: child, medication, route, time, and dose. Matching the <b><i>Five Rights</i></b> each time medication is given will help prevent medication errors. See Handout 2.1 and 2.2.
<b>generic name</b>	The name of the medication that is the same as the medication’s active ingredient.
<b>health care consultant</b>	A physician, physician assistant, nurse practitioner or registered nurse with a valid New York State license. The consultant is responsible for working closely with the child care program to develop and implement a safe and realistic health care plan that includes the administration of medication in the program. See NYS Day Care Regulation 413.2(ak).
<b>health care provider</b>	A licensed physician, physician assistant or nurse practitioner with a valid New York State license. See NYS Day Care Regulation 413.2(q).
<b>hives</b>	A skin condition characterized by itching and welts, caused by a reaction to internal or external agents, an infection or a nervous condition.
<b>illness</b>	The state of being sick.
<b>ineffective</b>	The absence of a desired effect, after allowing sufficient time for the medication to work.
<b>inhaler</b>	A device for administering medication into the nose, lungs or other part of the respiratory tract by breathing in the medication.
<b>independent medication administration</b>	When a child carries his own medication, decides when a dose is needed and takes the dose without supervision. See Handout 10.3.
<b>infant</b>	A child who is younger than eighteen (18) months of age. See NYS Day Care Regulation 413.2(s).

<b>licensed authorized prescriber</b>	A person licensed, currently registered and authorized under NYS Education Law to issue prescriptions for medication or medical treatment. Also called prescriber. See NYS Day Care Regulation 413.2(al).
<b>localized</b>	Confined or restricted to a particular location. The use of this term in this curriculum refers to how a mild allergic reaction might appear on a child's body part (e.g., a localized red skin rash on the stomach or a localized region of hives on the neck).
<b><i>Log of Medication Administration</i></b>	The OCFS-approved form that provides a written record for each medication given to a specific child.
<b>MAT</b>	An acronym for the <b>M</b> edication <b>A</b> dministration <b>T</b> raining course.
<b>MDI</b>	An acronym for <b>M</b> etered <b>D</b> ose <b>I</b> nhaler device. A metered-dose inhaler is used to deliver a precise dose of medication from a multi-dose container into the lungs.
<b>medication</b>	Any non-food substance used to treat a disease or illness or used to prevent or cure health problems.
<b>medication administrant</b>	A staff person who is listed in the day care program's approved health care plan as authorized to give medication in the program. This person must be at least 18 years old, have current CPR and first aid certificates covering the ages of the children in care and have a current MAT certificate. Only medication administrants approved by OCFS can give medication.
<b>medication administration</b>	The complete process of giving medication, observing and reporting desired and undesired effects and reviewing each step to maximize benefit and reduce risk.
<b>medication category</b>	A type or common grouping of medicine based on its purposes or general function.
<b>medication effects</b>	How medication affects the child. These effects may be desired or undesired.
<b>medication error</b>	A mistake made in giving the medication (for example, giving the incorrect medication, giving the medication at the incorrect time, giving the incorrect dose, using the incorrect route, giving the medication to the incorrect child, giving an expired medication, forgetting to give medication or giving medication when the child's written medication consent form or the medication is expired). See Handout 10.1.

<b>medication label</b>	The label on the pharmacy bottle or container that contains the information necessary to administer the medication safely.
<b>medication package</b>	The container in which the medication is supplied. This may sometimes contain important information such as side effects, special considerations and drug/food interaction.
<b>mucous membrane</b>	A membrane that lines body passages and cavities that are connected to the outside of the body. One example is the lining of the nose and mouth.
<b>nebulizer machine</b>	A compressor device that finely disperses a liquid drug for inhalation in a mist to be breathed into the body. This machine is used frequently for the treatment of asthma in children. See Handout 7.5.
<b>non-infant</b>	A child who is eighteen (18) months of age or older.
<b>nonprescription medication</b>	Medication that can be bought without a prescription from a licensed authorized prescriber. Also called over-the-counter medication.
<b>NYS</b>	Acronym for New York State.
<b>OCFS</b>	Acronym for the <b>Office of Children and Family Services</b> . OCFS is the New York State agency responsible for the regulations governing the safety and well-being of children receiving child care in New York State.
<b>OTC medication</b>	An acronym for <b>over-the-counter</b> medication.
<b>over-the-counter medication</b>	Another term for nonprescription medication. See “nonprescription medication” in this glossary.
<b>package insert</b>	The information provided on a separate sheet accompanying the medication package or container. It includes common side effects, warnings and administration information. This information may be printed directly on the medication package or container.
<b>peak flow meter</b>	A portable, handheld device used to measure how hard and fast the child can push air out of the lungs. Measurements with a peak flow meter help the child’s parent and physician monitor asthma. These measurements can be important in helping the child’s health care provider prescribe medicines to control asthma.
<b>pharmacy</b>	A licensed establishment where prescription medications are filled and dispensed by a pharmacist licensed under the laws of the state where (s)he practices.

<b>prescription medication</b>	Medication for a specific child that can only be bought with a written order from a licensed authorized prescriber to treat a specific condition.
<b>prescriber</b>	See “licensed authorized prescriber” in this glossary.
<b>PRN</b>	An acronym for the Latin <i>pro re nata</i> , meaning “as needed.” PRN medication is given when a child shows specific symptoms.
<b>route</b>	The way medication gets into the body; also called method of administration. See Handout 3.3.
<b>seizure</b>	A sudden attack, spasm, convulsion, extreme emotional change, or change in consciousness, as in epilepsy or another disorder.
<b>side effect</b>	The action of a drug other than the desired or sought-after effect. See Handout 3.1.
<b>symptoms</b>	Physical or behavioral signs that you can see, hear, measure, or smell that may tell you the child needs help, which may include giving medication.
<b>undesired effect</b>	Any effect other than the desired effect. Undesired effects are also called side effects, which include adverse effects and allergic reactions. See Handout 3.1.
<b>unintentional poisoning</b>	Unintended or unplanned ingestion of any substance, including medication. See Handout 9.1.
<b>verbal instructions/permissions</b>	Instructions received orally from a parent or guardian and/or the licensed authorized prescriber to administer medication. You can only accept verbal permissions and instructions in certain circumstances. See Handout 4.1.
<b>waiver request</b>	A written request from a day care program on an OCFS-approved form looking for approval to meet the intent of the regulations in a manner that is not specifically written in the regulations. The program cannot implement the waiver until OCFS approves the waiver request.
<b>written permission/instructions</b>	Permission and instructions for administering medication written on the OCFS-approved <i>Written Medication Consent Form</i> or approved equivalent completed by the child’s parent/guardian and/or health care provider. See Handout 4.1 and 4.2.
<b><i>Written Medication Consent Form</i></b>	The OCFS-approved form that provides written health care provider instructions and parental permission for each medication given to a specific child. There should be one form for each medication the child receives while in care. See Handout 4.2.

## What Are the *Five Rights?*



### 1. *Right Child*

- Make sure that the child you are about to give the medication to is the right child. If you care for siblings or other children in your program with similar names, be extra careful.
- If you need to give medication to a child you don't know well, ask someone you trust to tell you the child's name. You can also ask the child to tell you his/her name. But never rely solely on the child to tell you his/her name.



### 2. *Right Medication*

- Only accept medication that is in its original container with the original label. Don't accept medication that a person has put into another container because you have no way of knowing if it's the right medication.
- The strength of the medication is also part of the right medication. The strength is how much of the active ingredient is in one pill or one dose. For example, Ritalin® comes in 5mg and 10mg tablets. So in addition to checking the name (Ritalin®), make sure you have the right strength of the medication (5mg).



### 3. *Right Dose*

- The dose is how much of medication to give. For example, the dose could be one tablet, 2 teaspoons or one drop.
- Measure the dose correctly using the tool (medicine cup, dosing spoon, oral syringe) the parent gave you, if one is needed.
- If the medication is a liquid, make sure the tool the parent supplied, such as a dosing spoon, oral syringe or medicine cup, has the same measurement on it that is written on the consent form (teaspoons, tablespoons, cc's, etc.).



### 4. *Right Route*

- The route is the way the medication gets into the child's body, such as into the eye, rubbed on the skin or put into the mouth.
- Always ask if you don't you understand how to give the medication correctly by the route written.



### 5. *Right Time*

- Medication can be scheduled to be given at a specific hour or have instructions that tell you what to look for when the child needs the medication ("as needed").
- When a child arrives, check with the parent to find out if the child got any medication before coming to care.
- Give medication up to 30 minutes before or up to 30 minutes after the dose is due.



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## Matching the *Five Rights*



Giving medication is a very serious part of your job. Knowing the **Five Rights** is not enough. To give medication, you must match the medication, time, dose, route and child's first and last names written on the medication label or over-the-counter package to the information written on the consent form to be sure you're giving the medication correctly. This is called matching the **Five Rights**.

Remember the following when matching the **Five Rights** to give medication:

### Right Child

- Match the child's first and last names written on the consent form with the names written on the pharmacy label or package to the child you are about to give the medication to.

### Right Medication

- Make sure the medication listed on the label of the container exactly matches the *Written Medication Consent Form*. Be careful, because the names of medication can sound alike and be spelled alike, but be very different medication.
- Some medication, such as inhalers, EpiPens® and creams, are inside a box with a pharmacy label on it. Always take the medication container out of the labeled box and match the medication name on the container with the label, including the strength.



### Right Dose

- Match the dose written on the consent form with the dose written on the pharmacy label or package with the dose you have prepared to give.

### Right Route

- Match the route written on the consent form with the route written on the pharmacy label or package with the way you are about to give the medication to the child.

### Right Time

- Match the time written on the *Written Medication Consent Form* with the time written on the pharmacy label and package with the current time. Remember that if the health care provider did not write the hour to give it (e.g., 12:00 PM), check the back of the consent form to see what time the parent wrote for you to give it.
- If the medication is given when the child needs it instead of at a specific hour, match the information written on the consent form and make sure it matches the child's symptoms. For example, if the instructions say to give Tylenol® when the child has a fever of 101°F or above, you would know it's the right time to give it if the child has a fever of 102°F.

### Remembering the *Five Rights*

A mnemonic is a helpful device for remembering information. Here is a mnemonic to help you remember the *Five Rights* of medication administration:

## “Charlie Made Delicious Rich Toffee”

Charlie.....Child  
Made .....Medication  
Delicious .....Dose  
Rich.....Route  
Toffee.....Time

# OCFS-LDSS-7002: Written Medication Consent Form



OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: <b>RIGHT CHILD</b>		2. Date of Birth:		3. Child's Known Allergies:	
4. Name of Medication ( <i>including strength</i> ): <b>RIGHT MEDICATION</b>			5. Amount/Dosage to be Given: <b>RIGHT DOSE</b>		6. Route of Administration: <b>RIGHT ROUTE</b>
7A. Frequency to be administered: <b>RIGHT TIME (see #19)</b>					
<b>OR</b>					
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): <b>RIGHT TIME (for "as needed" medication)</b>					
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )					
<b>AND/OR</b>					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____					
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )					
<b>AND/OR</b>					
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____					
11. Reason for medication ( <i>unless confidential by law</i> ): _____					
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.					
14. Date Health Care Provider Authorized:			15. Date to be Discontinued or Length of Time in Days to be Given:		
16. Licensed Authorized Prescriber's Name (please print):			17. Licensed Authorized Prescriber's Telephone Number:		
18. Licensed Authorized Prescriber's Signature: <b>X</b>					

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
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**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): **RIGHT TIME (if not in Box 7A)**

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):

21. Parent's Name (please print):

22. Date Authorized:

23. Parent's Signature:

X

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

24. Program Name:

25. Facility ID Number:

26. Program Telephone Number:

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 day care program.

28. Staff's Name (please print):

29. Date Received from Parent:

30. Staff Signature:

X

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

## Exercise: Finding the *Five Rights*



### Case Study 1: Over-the-Counter Medication

Directions: Circle each of the **Five Rights** on the medication package below. Write each Right on the line provided. Then, circle the **Five Rights** on the *Written Medication Consent Form* on the next page and match each one with the **Five Rights** on the medication package.



<b>Drug Facts</b>	
<b>Active ingredient</b>	<b>Purpose</b>
Benzocaine 7.5%	Oral pain reliever
<b>Use</b> for the temporary relief of sore gums due to teething in children 2 years of age and older. For use in children under the age of 2, consult a physician or healthcare provider.	
<b>Warnings</b>	
<b>Allergy alert:</b> do not use this product if your child has a history of allergy to local anesthetics such as procaine, butacaine, benzocaine or other "caine" anesthetics	
<b>Do not use</b> ■ more than directed ■ for more than 7 days unless directed by a physician or healthcare provider	
<b>When using this product</b> ■ fever and nasal congestion are not symptoms of teething and may indicate the presence of infection. If these symptoms persist, consult your physician.	
<b>Stop use and ask a physician if</b> ■ sore mouth symptoms do not improve in 7 days ■ irritation, pain or redness does not go away ■ swelling, rash or fever develops	
<b>Keep out of reach of children.</b> In case of overdose or allergic reaction, get medical help or contact a Poison Control Center right away.	
<b>Directions</b> ■ wash hands ■ cut open tip of tube on score mark ■ use your fingertip or cotton applicator to apply a small pea-size amount of Orajel and spread over the gums ■ apply to the affected area up to 4 times daily or as directed by a physician or healthcare provider ■ for children under 2 years of age, consult a physician or healthcare provider	
<b>Other information</b> do not use if tube tip is cut prior to opening	
<b>Inactive ingredients</b> cellulose gum, flavor, gelatin, mineral oil, pectin, petrolatum, polyethylene glycol, red 40, sodium saccharin	
<b>Questions or comments?</b> call us at 1-800-952-5080 M-F 9am-5pm ET or visit our website at <a href="http://www.oraljel.com">www.oraljel.com</a>	

1. Right Child: \_\_\_\_\_
2. Right Medication: \_\_\_\_\_
3. Right Dose: \_\_\_\_\_
4. Right Route: \_\_\_\_\_
5. Right Time: \_\_\_\_\_



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**MEDICATION CONSENT FORM**  
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- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: Missy Franklin		2. Date of Birth: 4-3-XX (6 months old)		3. Child's Known Allergies: None known	
4. Name of Medication ( <i>including strength</i> ): Orajel 7.5%			5. Amount/Dosage to be Given: Small pea-size amount		6. Route of Administration: apply to red or swollen gums
7A. Frequency to be administered: _____					
<b>OR</b>					
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): <u>increased irritability, fussiness and/or red, swollen and painful gums; apply no more than 2 times a day while in care.</u>					
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )					
<b>AND/OR</b>					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____					
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )					
<b>AND/OR</b>					
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____					
11. Reason for medication ( <i>unless confidential by law</i> ): <u>Discomfort due to teething</u>					
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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.					
14. Date Health Care Provider Authorized: 9/29/XX			15. Date to be Discontinued or Length of Time in Days to be Given:		
16. Licensed Authorized Prescriber's Name (please print): Margaret Valens, M.D.			17. Licensed Authorized Prescriber's Telephone Number: (718) 555-2345		
18. Licensed Authorized Prescriber's Signature: <b>X</b> <i>Margaret Valens, MD</i>					

OCFS-LDSS-7002 (5/2015) REVERSE

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**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):  
Missy Franklin

21. Parent's Name (please print):  
Andrea Franklin

22. Date Authorized:  
9/29/XX

23. Parent's Signature:  
**X** *Andrea Franklin*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (please print):  
Carla Carson

29. Date Received from Parent:  
9/29/20XX

30. Staff Signature:  
**X** *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:  
**X**

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:  
**X**

**Case Study 2: Prescription Medication**

Directions: Circle each of the **Five Rights** on the prescription label below. Write each Right on the line provided. Then, circle the **Five Rights** on the *Written Medication Consent Form* on the next page and match each one with the **Five Rights** on the label.

**Pharmacy Inc. #0012 Ph: 914-555-0102**  
100 Main Street, NYC, NY 10068  
Rx#: 8145973-02 Tx: 8063264

**Jose Martinez DOB: 11/30/XX**  
(914) 554-1984  
461 Park Place, Brooklyn, NY 11202

**albuterol (90mcg/inh)**  
(generic form of Ventolin®)

**Give two puffs by oral inhaler as directed. May give every four hours up to three doses per day.**

Prescriber: **Nancy Wallace MD (914) 564-9832**  
221 Stream Place, Brooklyn, NY 11202  
Refillable: 0 times QTY: 1 R.Ph. Init: RSL  
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/XX

1. Right Child: \_\_\_\_\_
2. Right Medication: \_\_\_\_\_
3. Right Dose: \_\_\_\_\_
4. Right Route: \_\_\_\_\_
5. Right Time: \_\_\_\_\_



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- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: José Martinez		2. Date of Birth: 11-30-XX (6 years old)	3. Child's Known Allergies: Dust, pollen
4. Name of Medication ( <i>including strength</i> ): Albuterol 90mcg/inh		5. Amount/Dosage to be Given: 2 puffs	6. Route of Administration: inhaled
7A. Frequency to be administered: _____			
<b>OR</b>			
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): <u>Difficulty breathing, wheezing, and/or shortness of breath. May repeat dose in four hours, if needed.</u>			
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )			
<b>AND/OR</b>			
8B. Additional side effects: _____			
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____			
10A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )			
<b>AND/OR</b>			
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____			
11. Reason for medication ( <i>unless confidential by law</i> ): <u>Asthma</u>			
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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes   If you checked yes, complete (#33 and #35) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes   If you checked yes, complete (#34 -#35) on the back of this form.			
14. Date Health Care Provider Authorized: 7/15/XX		15. Date to be Discontinued or Length of Time in Days to be Given:	
16. Licensed Authorized Prescriber's Name (please print): Nancy Wallace, M.D.		17. Licensed Authorized Prescriber's Telephone Number: (718) 564-9832	
18. Licensed Authorized Prescriber's Signature: <b>X</b> <i>Nancy Wallace, MD</i>			

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**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):  
José Martinez

21. Parent's Name (please print):  
Alicia Martinez

22. Date Authorized:  
7/15/XX

23. Parent's Signature:

X *Alicia Martinez*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (please print):  
Carla Carson

29. Date Received from Parent:  
7/15/XX

30. Staff Signature:

X *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

See Individual Health Care Plan

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X *Nancy Wallace, MD*

## Exercise: Finding the *Five Rights* ANSWER KEY



### Case Study 1: Over-the-Counter Medication

Medication →



Missy Franklin

← Child

Dose →

**Drug Facts**

Active ingredient	Purpose
Benzocaine 7.5%	Oral pain reliever
<b>Use</b> for the temporary relief of sore gums due to teething in children 2 years of age and older. For use in children under the age of 2, consult a physician or healthcare provider.	
<b>Warnings</b>	
<b>Allergy alert:</b> do not use this product if your child has a history of allergy to local anesthetics such as procaine, butacaine, benzocaine or other "caine" anesthetics	
<b>Do not use</b> ■ more than directed ■ for more than 7 days unless directed by a physician or healthcare provider	
<b>When using this product</b> ■ fever and nasal congestion are not symptoms of teething and may indicate the presence of infection. If these symptoms persist, consult your physician.	
<b>Stop use and ask a physician if</b> ■ sore mouth symptoms do not improve in 7 days ■ irritation, pain or redness does not go away ■ swelling, rash or fever develops	
<b>Keep out of reach of children.</b> In case of overdose or allergic reaction, get medical help or contact a Poison Control Center right away.	
<b>Directions</b> ■ wash hands ■ cut open tip of tube on score mark ■ use your fingertip or cotton applicator to apply a small pea-size amount of Orajel and spread over the gums ■ apply to the affected area up to 4 times daily or as directed by a physician or healthcare provider ■ for children under 2 years of age, consult a physician or healthcare provider	
<b>Other information</b> do not use if tube tip is cut prior to opening	
<b>Inactive ingredients</b> cellulose gum, flavor, gelatin, mineral oil, pectin, petrolatum, polyethylene glycol, red 40, sodium saccharin	
<b>Questions or comments?</b> call us at 1-800-952-5080 M-F 9am-5pm ET or visit our website at <a href="http://www.oraljel.com">www.oraljel.com</a>	

Time / Route

1. Right Child: Missy Franklin
2. Right Medication: Orajel 7.5%
3. Right Dose: small pea-size amount
4. Right Route: Apply to red or swollen gums. (Label states "as directed," so follow the health care provider instructions when matching the right route.)
5. Right Time: When Missy shows these symptoms: increased irritability, fussiness and/or red, swollen and painful gums due to teething. (Label states "as directed," so follow the health care provider instructions when matching the right time.)



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- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#31) AND AS NEEDED (#33 - 35)**

1. Child's First and Last Name: Missy Franklin	2. Date of Birth: 4-3-XX (6 months old)	3. Known Allergies: None known
4. Name of Medication (including strength): Orajel 7.5%	5. Amount/Dosage to be Given: Small pea-size amount	6. Route of Administration: apply to red or swollen gums
7A. Frequency to be administered: _____		
<b>OR</b>		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and when possible, measurable parameters): increased irritability, fussiness and/or red, swollen and painful gums; apply no more than 2 times a day while in care.		
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects (parent must supply)		
<b>AND/OR</b>		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply)		
<b>AND/OR</b>		
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 situation's when medication should not be administered.) _____		
11. Reason for medication (unless confidential by law): Discomfort due to teething		
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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.		
14. Date Health Care Provider Authorized: 9/29/XX	15. Date to be Discontinued or Length of Time in Days to be Given:	
16. Licensed Authorized Prescriber's Name (please print): Margaret Valens, M.D.	17. Licensed Authorized Prescriber's Telephone Number: (718) 555-2345	
18. Licensed Authorized Prescriber's Signature: X <i>Margaret Valens, MD</i>		

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**PARENT 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 licensed authorized prescriber write 12pm?*)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (*i.e.: 12 pm*): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (*child's name*):  
Missy Franklin

21. Parent's Name (*please print*):  
Andrea Franklin

22. Date Authorized:  
9/29/XX

23. Parent's Signature:  
**X** *Andrea Franklin*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (*please print*):  
Carla Carson

29. Date Received from Parent:  
9/29/20XX

30. Staff Signature:  
**X** *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:  
**X**

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:  
**X**

**Case Study 2: Prescription Medication**

**Pharmacy Inc. #0012 Ph: 914-555-0102**  
100 Main Street, NYC, NY 10068  
Rx#: 8145973-02 Tx: 8063264

Child

**Jose Martinez** **DOB: 11/30/XX**  
(914) 554-1984  
461 Park Place, Brooklyn, NY 11202

Medication

**albuterol (90mcg/inh)**  
(generic form of Ventolin®)

Time / Route

Dose

Give **two puffs** by oral inhaler as directed. May give every four hours up to three doses per day.

Prescriber: **Nancy Wallace MD (914) 564-9832**  
221 Stream Place, Brooklyn, NY 11202  
Refillable: 0 times QTY: 1 R.Ph. Init: RSL  
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/XX

1. Right Child: José Martínez
2. Right Medication: albuterol 90 mcg/inh
3. Right Dose: 2 puffs
4. Right Route: inhaled by oral inhaler
5. Right Time: When José shows these symptoms: shortness of breath, wheezing, complaint of difficulty breathing. (Label states "as directed," so follow the health care provider instructions when matching the right time.)



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OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#33 - 35) AND AS NEEDED (#33 - 35)**

1. Child's First and Last Name: José Martinez  
2. Date of Birth: 11-30-XX (6 years old)  
3. Known Allergies: \_\_\_\_\_, pollen

4. Name of Medication (including strength): Albuterol 90mcg/inh  
5. Amount/Doseage to be Given: 2 puffs  
6. Route of Administration: inhaled

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): Difficulty breathing, wheezing, and/or shortness of breath. May repeat dose in four hours, if needed.

8A. Possible side effects:  See package insert for complete list of possible side effects (parent must supply)

**AND/OR**

8B. Additional side effects: \_\_\_\_\_

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

Contact parent  Contact health care provider at phone number provided below

Other (describe): \_\_\_\_\_

10A. Special instructions:  See package insert for complete list of special instructions (parent must supply)

**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 situation's when medication should not be administered.) \_\_\_\_\_

11. Reason for medication (unless confidential by law): Asthma

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 and #35) 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 (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: 7/15/XX  
15. Date to be Discontinued or Length of Time in Days to be Given: \_\_\_\_\_

16. Licensed Authorized Prescriber's Name (please print): Nancy Wallace, M.D.  
17. Licensed Authorized Prescriber's Telephone Number: (718) 564-9832

18. Licensed Authorized Prescriber's Signature:

Nancy Wallace, MD

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):  
José Martinez

21. Parent's Name (please print):  
Alicia Martinez

22. Date Authorized:  
7/15/XX

23. Parent's Signature:  
 *Alicia Martinez*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (please print):  
Carla Carson

29. Date Received from Parent:  
7/15/XX

30. Staff Signature:  
 *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.  
See Individual Health Care Plan

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:  
 *Nancy Wallace, MD*

## Medication Effects

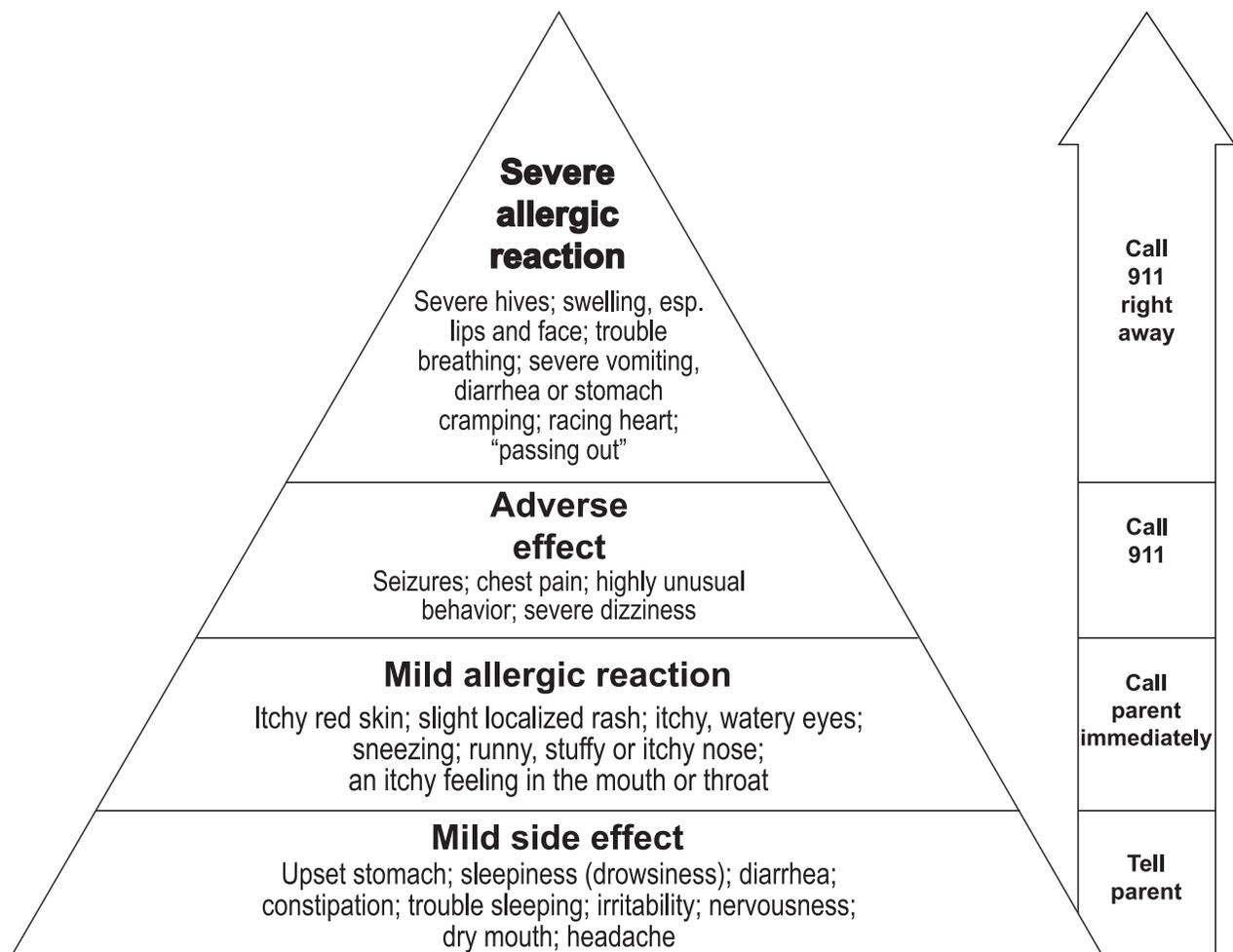


Medication is given for many reasons. If it works right, it has the “desired effect.”

Medication can be given to:

- **prevent illness** (e.g., getting the polio vaccine so you don’t get polio);
- **control health problems** (e.g., taking medication every day to help prevent seizures);
- **cure an illness** (e.g., taking an antibiotic to get rid of an ear infection); or
- **reduce symptoms** (e.g., taking Tylenol® to lower a fever).

Taking medication has effects on a child’s body. These effects can be wanted (desired effect), unwanted or even dangerous. Whenever a child in your care is taking medication, watch the child and pay attention if the child acts or feels different than usual. If you notice any changes, contact the child’s parent. These changes could be unwanted effects from the medication. If the child is having a severe reaction and an adverse effect to a medication, call 911 right away and then call the child’s parent.





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## Medication Routes



Medication can get into a child's body in many ways. The most common ways for medication to be absorbed into a child's body is through the lining of the stomach and intestines, through the skin or through the lining of the lungs. The way medication is taken, so it can be absorbed into the body, is called the medication **route**.

In this course you will learn seven ways (routes) to give medication:

- On the skin (topically)
- By mouth (orally; includes topically applied in the mouth)
- Inhaled through the mouth or nose
- By using medicated patches
- By putting it in the ear
- By putting it in the eye
- By using an auto-injector, like an EpiPen® or Auvi-Q™, to give a shot of epinephrine to prevent anaphylaxis.

Routes **not** covered in this course include:

- Rectal
- Vaginal
- Injection

If a child in your program needs medication given rectally, vaginally or by injection, you will need to get additional training, beyond this course. For more information on the steps you need to take before you are able to give medication by routes other than the ones listed above, see Module 10.



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## Overview of the Medication Routes Covered in the MAT Course



Route	Forms of the medication	How fast does the medication start working?
<p><b>1. Topical</b> medication is put on the skin.</p>	<p>Medication put on the skin can be a:</p> <ul style="list-style-type: none"> <li>• cream</li> <li>• lotion</li> <li>• ointment</li> <li>• gel</li> <li>• aerosol</li> </ul>	<p>Depends on the medication</p>
<p><b>2. Oral</b> medication is given by mouth.</p>	<p>Medication taken by mouth can come in many forms, including:</p> <ul style="list-style-type: none"> <li>• tablets</li> <li>• capsules</li> <li>• liquids</li> </ul>	<p>Usually starts working in about 30-60 minutes.</p> <p>Some things that can affect how fast the medication starts working:</p> <ul style="list-style-type: none"> <li>• Amount of food in stomach</li> <li>• Activity level</li> <li>• If the medication has a coating on it</li> </ul>
	<ul style="list-style-type: none"> <li>• sprinkles (small granules that can be sprinkled onto food or onto the tongue). Sprinkles can come in small packets or in capsules that can be opened and poured out.</li> <li>• wafers/dissolving strips/ melts (medication that is placed on the tongue or in the mouth, where it dissolves)</li> <li>• sublingual medication (medication that is placed under the tongue, where it dissolves)</li> <li>• gels that are rubbed into the gums or inside the mouth</li> </ul>	<p>Rapid absorption; effects usually noted within 10 minutes.</p>

Route	Forms of the medication	How fast does the medication start working?
<p><b>3. Inhaled</b> medication is breathed in through the nose or mouth.</p>	<p>Medication breathed in through the nose can be given by:</p> <ul style="list-style-type: none"> <li>• spray</li> <li>• drop</li> <li>• nebulizer</li> </ul>	<p>Usually starts working in about 10 to 15 minutes</p>
	<p>Medication breathed in through the mouth can be given by:</p> <ul style="list-style-type: none"> <li>• inhaler, such as metered-dose inhaler or dry powder inhaler</li> <li>• nebulizer, a machine that changes liquid medication into a mist that can be breathed in by the nose or mouth</li> </ul>	<p>Usually starts working in about 5 to 15 minutes</p>
<p><b>4. Medicated patches</b> are patches with medication in them that are put on the skin and kept on the skin for a period of time.</p>	<p>Medication comes in the form of a patch.</p>	<p>Small amounts of medication are absorbed slowly, in a controlled manner, over a period of time.</p>
<p><b>5. Eye</b> medication is placed into the eye.</p>	<p>Medication put into the eye can be:</p> <ul style="list-style-type: none"> <li>• drop</li> <li>• ointment</li> </ul>	<p>Usually right away</p>
<p><b>6. Ear</b> medication is placed into the ear.</p>	<p>Medication comes in a liquid to be dropped into the ear.</p>	<p>Depends on the medication</p>
<p><b>7. Auto-injector</b> for giving the medication epinephrine to a child having a serious allergic reaction.</p>	<p>This medication, epinephrine, comes in an auto-injector device that allows you to put a pre-measured amount of the medication into the body through the skin using a needle.</p>	<p>Usually right away</p>

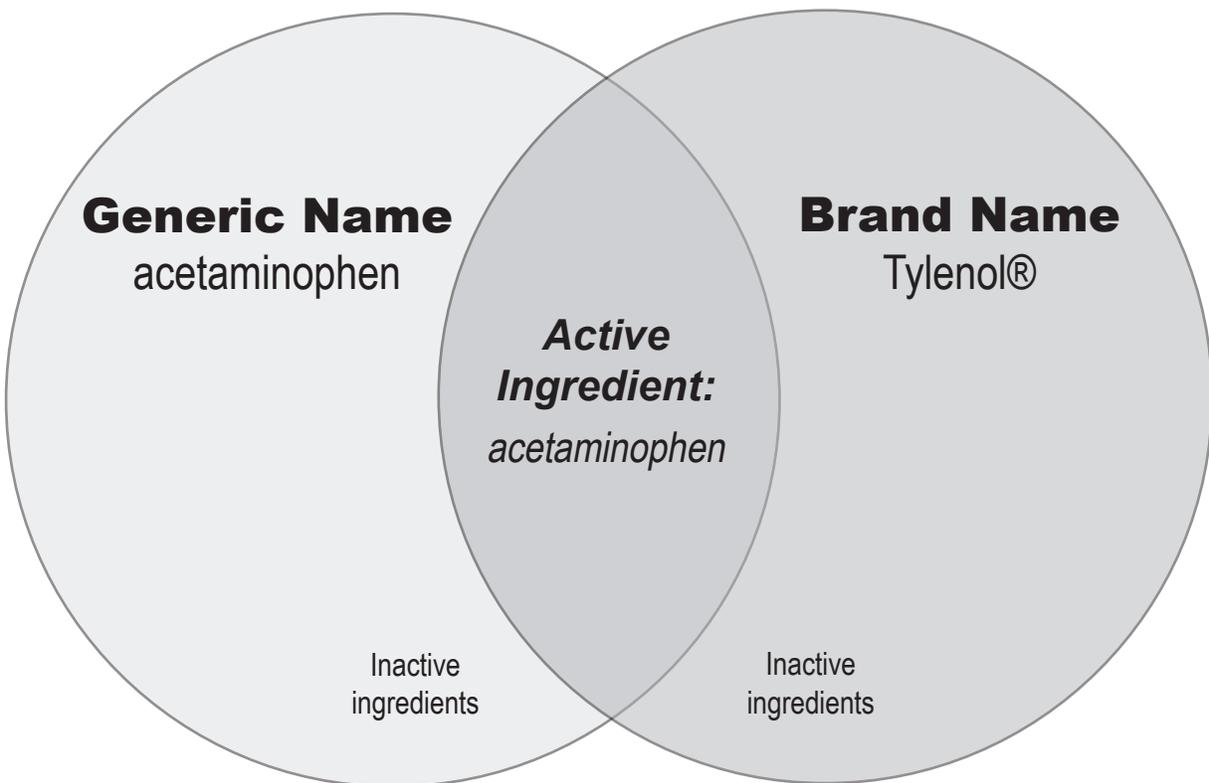
## Types of Medication



Medication Type	What Will the Medication Look Like?	Common Examples
<p><b>Over-the-counter</b> (nonprescription): Medication that you can get without an order from a licensed authorized prescriber.</p>	<p>Over-the-counter medications all look different. The instructions for use on the label are not specific to the child.</p> <p>(Food/nutrition products, lotion, lip balm, medicated bandages, topical ointments, sunscreen, insect repellent and Vaseline® are not considered medication.)</p>	<p>Tylenol®, Dimetapp®, Motrin®, ibuprofen, Benadryl®, homeopathic treatments such as herbs and vitamins</p>
<p><b>Prescription:</b> Medication that needs an order by a licensed authorized prescriber to get medicine from the pharmacy.</p>	<p>All prescription medication comes in a container/bottle with a pharmacy label. The pharmacy label will be for a <b>specific child</b> and will have instructions for giving the medication.</p>	<p>amoxicillin, albuterol, EpiPen®, Ritalin®, Cortisporin Otic®, Augmentin®</p>
<p><b>Controlled Substances:</b> Medication designated as having a high potential for misuse, which are regulated by the federal government.</p>	<p>Controlled substances will have a label on the medication container that tells you it is a controlled substance. The label is usually bright orange or yellow and will have the words “controlled substance” written on it.</p>	<p>Ritalin® and Focalin®</p>
<p><b>Brand name:</b> The name given to the medication by the pharmaceutical company that created it.</p>	<p>The medication name on the label will have the symbol ® after it to identify it as a registered trademark.</p>	<p>Tylenol®, Motrin®, Cipro®, Benadryl®, Ventolin®</p>
<p><b>Generic name:</b> The name of the active ingredient in the medication.</p>	<p>The medication name on the label will be listed as the “active ingredient.”</p>	<p>amoxicillin, acetaminophen, ibuprofen, diphenhydramine, albuterol</p>

**Example of the Difference Between a Medication’s Brand Name and Its Generic Name**

Tylenol® is a brand name medication. The active ingredient in Tylenol® is acetaminophen. If you buy a medication named “acetaminophen” in the store, you are buying a generic medication. Both the generic and brand name medications have the same active ingredient (acetaminophen), but may be slightly different from one another because of the inactive ingredients. **See diagram.**



## Exercise: Handling Effects from Medication



**Case Study 1:** Carmen is a three-year-old child in your program. She is being treated for an ear infection. Her doctor wrote a prescription for her to take a liquid antibiotic called amoxicillin, given by mouth for ten days. Since she needs the medication three times a day, you are giving her a dose every day at 2PM.

The instructions on Carmen's *Written Medication Consent Form* tell you to look at the package insert for possible side effects. Carmen's mother gave you the following drug information sheet, which she received from the pharmacy:

DRUG INFORMATION SHEET
<b>DRUG NAME: AMOXICILLIN SUS 250/5ML</b>
<b>GENERIC NAME: AMOXICILLIN (a-mox-i-SILL-in)</b>
<b>HOW TO USE THIS MEDICINE:</b> Follow the directions for using this medicine provided by your doctor. THIS MEDICINE MAY BE TAKEN on an empty stomach or with food. TO CLEAR UP YOUR INFECTION COMPLETELY, continue taking this medicine for the full course of treatment even if you feel better in a few days. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible.
<b>CAUTIONS:</b> DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a penicillin antibiotic or a cephalosporin antibiotic. IF YOU EXPERIENCE difficulty breathing or tightness of chest; swelling of eyelids, face, or lips; or develop a rash of hives, tell your doctor immediately. Do not take any more of this medicine unless your doctor tells you to do so.
<b>POSSIBLE SIDE EFFECTS:</b> SIDE EFFECTS that may go away during treatment include nausea, vomiting, mild diarrhea, or irritation of mouth or throat. If they continue or are bothersome, check with your doctor. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse or pharmacist.

Using Handout 3.1 and the drug information sheet above, answer these questions:

1. On the Drug Information Sheet, circle the side effects that Carmen may get from the amoxicillin.
2. Carmen tells you she doesn't feel good and her tummy hurts about an hour after you gave her the amoxicillin. What should you do?

---

---

**Case Study 2:** Kristopher is a four-year-old in your program. He is allergic to pollen, grass and trees. His parents gave you instructions from his doctor to give him Diphedryl® (diphenhydramine) to help treat the itchy eyes and runny nose he gets.

The instructions on Kristopher’s *Written Medication Consent Form* tell you to look at the package insert for possible side effects. Below is the medication package Kristopher’s mother gave you:

FOR YOUR PROTECTION.

### Drug Facts

<b>Active ingredient</b> (in each 5 mL teaspoonful)	<b>Purpose</b>
Diphenhydramine HCl 12.5 mg .....	Antihistamine

**Uses**

- temporarily relieves these symptoms due to hay fever or other upper respiratory allergies:
  - sneezing      ■ itching of the nose or throat
  - runny nose   ■ itchy, watery eyes
- temporarily relieves these symptoms due to the common cold:
  - sneezing      ■ runny nose

**Warnings**

**Do not use** with any other product containing diphenhydramine, even one used on skin

**Ask a doctor before use if you have**

- a breathing problem such as emphysema or chronic bronchitis   ■ glaucoma
- trouble urinating due to an enlarged prostate gland
- a sodium-restricted diet

**Ask a doctor or pharmacist before use if you are taking sedatives or tranquilizers**

**When using this product**

- avoid alcoholic drinks
- marked drowsiness may occur
- excitability may occur, especially in children
- alcohol, sedatives and tranquilizers may increase drowsiness
- be careful when driving a motor vehicle or operating machinery

**If pregnant or breast-feeding,** ask a health professional before use.

**Keep out of reach of children.** In case of overdose, get medical help or contact a Poison Control Center right away.

**Directions**

- if needed, take every 4-6 hours
- do not take more than 6 doses in 24 hours

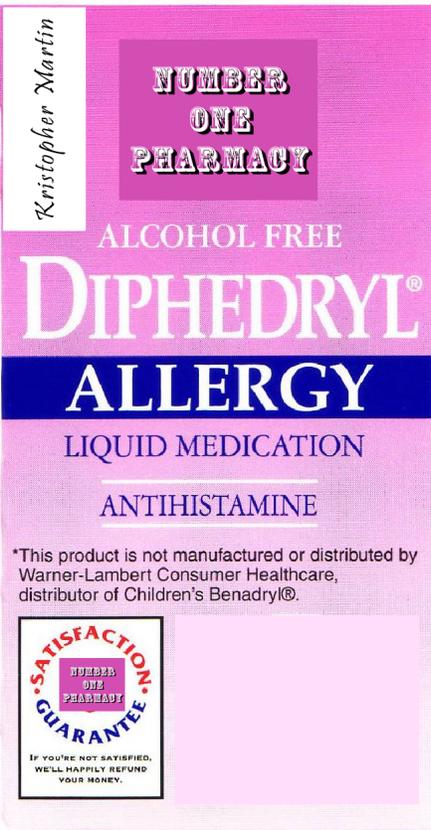
children under 6 years of age	ask a doctor
children 6 to under 12 years of age	1 to 2 teaspoonfuls (12.5 mg to 25 mg)
adults and children 12 years of age and over	2 to 4 teaspoonfuls (25 mg to 50 mg) ▶

**Drug Facts** (continued)

**Other information**

- each teaspoonful contains: sodium 15 mg
- store at 20°-25°C (68°-77°F)

**Inactive ingredients** citric acid, D&C red no. 33, FD&C red no. 40, flavor, glycerin, high fructose corn syrup, poloxamer 407, purified water, sodium benzoate, sodium chloride, sodium citrate, sorbitol



Using Handout 3.1 and the medication package above, answer these questions:

1. On the medication package, circle the undesired effects that Kristopher may get from the Diphedryl®.
2. About 30 minutes after giving Kristopher the medication, he is running around acting hyper and is having trouble calming down. What do you think is happening?

What should you do? \_\_\_\_\_

## Exercise: Identifying Types of Medication



**Directions:** Answer the questions using the package or medication label.

### Example 1



**Infants' TYLENOL®**  
Acetaminophen Pain Reliever-Fever Reducer  
**NEW! SimpleMeasure™**

See New Dosage & Directions  
NDC 50980-191-01  
**Infants' TYLENOL®**  
For Children  
Acetaminophen Oral Suspension  
Pain Reliever-Fever Reducer

**INFANTS**

**NEW! Dosage & Directions**

lbuprofen Free  
Alcohol Free  
Aspirin Free

Use Only Enclosed Syringe  
**SimpleMeasure™**  
See side panel for more information

**Grape**  
FLAVOR  
1 fl oz (30 mL)  
160 mg per 5 mL

**Drug Facts (continued)**

- replace cap lightly to maintain child resistance

Dosing Chart		
Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL

\* or as directed by a doctor  
Attention: use only enclosed syringe specifically designed for use with this product. Do not use any other dosing device.

**Other information**

- store between 20-25°C (68-77°F)
- do not use if carbon tape imprinted "SAFETY SEAL®" or bottle wrap imprints "SAFETY SEAL®" and "USE WITH ENCLOSED DOSING DEVICE ONLY" is broken or missing
- see bottom panel for lot number and expiration date

**Inactive ingredients** anhydrous citric acid, butylparaben, D&C red #33, FD&C blue #1, flavors, glycerin, high fructose corn syrup, microcrystalline cellulose and carboxymethylcellulose sodium, propylene glycol, purified water, sodium benzoate, sorbitol solution, sucralose, xanthan gum

**Questions or comments?**  
call 1-877-993-3665

**Drug Facts**

Active ingredient (in each 5 mL)	Purpose
Acetaminophen 160 mg	Pain reliever/fever reducer

**Uses** temporarily; reduces fever  
relieves minor aches and pains due to:  
the common cold flu headache sore throat toothache

**Warnings**  
Liver warning: This product contains acetaminophen. Severe liver damage may occur if your child takes more than 5 doses in 24 hours, which is the maximum daily amount  
with other drugs containing acetaminophen  
Sore throat warning: If sore throat is severe, persists for more than 2 days, is accompanied or followed by fever, headache, rash, nausea, or vomiting, consult a doctor promptly.

**Do not use**  
with any other drug containing acetaminophen (prescription or nonprescription). If you are not sure whether a drug contains acetaminophen, ask a doctor or pharmacist.  
if your child is allergic to acetaminophen or any of the inactive ingredients in this product

**Ask a doctor before use if your child has liver disease**  
**Ask a doctor or pharmacist before use if your child is taking the blood thinning drug warfarin**

**When using this product do not exceed recommended dose (see overdose warning)**

**Stop use and ask a doctor if**  
pain gets worse or lasts more than 5 days  
fever gets worse or lasts more than 3 days  
new symptoms occur  
redness or swelling is present  
These could be signs of a serious condition.

**Keep out of reach of children. Overdose warning:** Taking more than the recommended dose (overdose) may cause liver damage. In case of overdose, get medical help or contact a Poison Control Center right away. (1-800-222-1222) Quick medical attention is critical for adults as well as for children even if you do not notice any signs or symptoms.

**Directions**  
this product does not contain directions or complete warnings for adult use.  
do not give more than directed (see overdose warning)  
shake well before using  
mL = milliliter  
find right dose on chart. If possible, use weight to dose; otherwise, use age.  
push air out of syringe. Firmly push syringe into bottle opening  
turn bottle upside down and pull syringe to the correct dose  
dispense liquid slowly into child's mouth, toward inner cheek  
repeat dose every 4 hours while symptoms last  
do not give more than 5 times in 24 hours

**NEW! SimpleMeasure™**

**STEP 1.** See Directions for the correct dose for your child.

**STEP 2.** Shake well before using.

**STEP 3.** Push air out of syringe. Firmly push syringe into bottle opening.

**STEP 4.** Turn the bottle upside down and pull syringe to the correct dose.

**STEP 5.** Dispense liquid slowly into child's mouth.

**IMPORTANT:**  
New Dosage and Directions. Please see dosing chart or ask a doctor for your child's correct dose.

LOT: **ABC987**  
EXP: **09/XX**

1. Is this medication over-the-counter or prescription? How can you tell?
2. Is this medication a brand name or generic name medication? How can you tell?
3. What is the active ingredient?

**Example 2**

**Pharmacy Inc.** #0012 **Ph: 212-555-0102**

100 Main Street, New York, NY 10068

Rx#: 8145973-02 Tx: 8063264

**Michael Brown DOB: 06/04/XX**

(718) 554-1984

461 Park Place, Brooklyn, NY 11202

**EpiPen® Jr. (0.15 mg)**

**administer one dose (0.15mg) via autoinjection as needed for signs of anaphylaxis including: difficulty breathing; difficulty swallowing; hives; loss of consciousness; severe vomiting, diarrhea or abdominal cramps.**

Prescriber: **Nancy Wallace MD (718) 564-9832**

221 Stream Place, Brooklyn, NY 11202

Refillable: 0 times QTY: 1 injector R.Ph. Init: RSL

Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. date: 7/15/XX

1. Is this medication over-the-counter or prescription? How can you tell?

2. Is this medication a brand name or generic name medication? How can you tell?

## Exercise: Handling Effects from Medication

### ANSWER KEY



**Case Study 1:** Carmen is a three-year-old child in your program. She is being treated for an ear infection. Her doctor wrote a prescription for her to take a liquid antibiotic called amoxicillin, given by mouth for ten days. Since she needs the medication three times a day, you are giving her a dose every day at 2PM.

The instructions on Carmen's *Written Medication Consent Form* tell you to look at the package insert for possible side effects. Carmen's mother gave you the following drug information sheet, which she received from the pharmacy:

DRUG INFORMATION SHEET
<b>DRUG NAME: AMOXICILLIN SUS 250/5ML</b>
<b>GENERIC NAME: AMOXICILLIN (a-mox-i-SILL-in)</b>
<b>HOW TO USE THIS MEDICINE:</b> Follow the directions for using this medicine provided by your doctor. THIS MEDICINE MAY BE TAKEN on an empty stomach or with food. TO CLEAR UP YOUR INFECTION COMPLETELY, continue taking this medicine for the full course of treatment even if you feel better in a few days. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible.
<b>CAUTIONS:</b> DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a penicillin antibiotic or a cephalosporin antibiotic. IF YOU EXPERIENCE difficulty breathing or tightness of chest; swelling of eyelids, face, or lips; or develop a rash of hives, tell your doctor immediately. Do not take any more of this medicine unless your doctor tells you to do so.
<b>POSSIBLE SIDE EFFECTS:</b> SIDE EFFECTS that may go away during treatment include nausea, vomiting, mild diarrhea, or irritation of mouth or throat. If they continue or are bothersome, check with your doctor. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse or pharmacist.

Using Handout 3.1 and the drug information sheet above, answer these questions:

1. On the Drug Information Sheet, circle the side effects that Carmen may get from the amoxicillin.



Answer Key 3.1

2. Carmen tells you she doesn't feel good and her tummy hurts about an hour after you gave her the amoxicillin. What should you do?

Check Carmen's *Written Medication Consent Form* for instructions from the health care provider (box 9 on the form). Also, contact Carmen's parent and write down on her *Log of Medication Administration* (in the Side Effects column) that Carmen got an upset stomach.

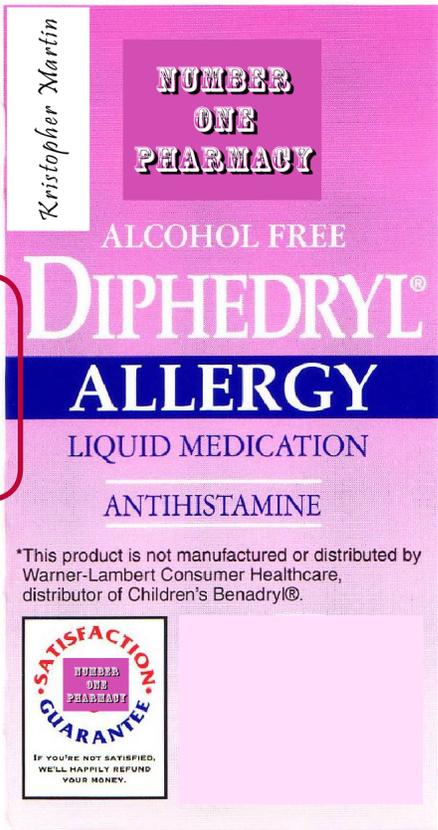
**Case Study 2:** Kristopher is a four-year-old in your program. He is allergic to pollen, grass and trees. His parents gave you instructions from his doctor to give him Diphedryl® (diphenhydramine) to help treat the itchy eyes and runny nose he gets.

The instructions on Kristopher’s *Written Medication Consent Form* tell you to look at the package insert for possible side effects. Below is the medication package Kristopher’s mother gave you:

FOR YOUR PROTECTION.

Drug Facts							
<b>Active ingredient</b> (in each 5 mL teaspoonful)	<b>Purpose</b>						
Diphenhydramine HCl 12.5 mg .....	Antihistamine						
<b>Uses</b>							
<ul style="list-style-type: none"> <li>■ temporarily relieves these symptoms due to hay fever or other upper respiratory allergies:               <ul style="list-style-type: none"> <li>■ sneezing</li> <li>■ itchy, watery eyes</li> </ul> </li> <li>■ temporarily relieves these symptoms due to the common cold:               <ul style="list-style-type: none"> <li>■ sneezing</li> <li>■ runny nose</li> </ul> </li> </ul>							
<b>Warnings</b>							
<p><b>Do not use</b> with any other product containing diphenhydramine, even one used on skin</p> <p><b>Ask a doctor before use if you have</b></p> <ul style="list-style-type: none"> <li>■ a breathing problem such as emphysema or chronic bronchitis</li> <li>■ glaucoma</li> <li>■ trouble urinating due to an enlarged prostate gland</li> <li>■ a sodium-restricted diet</li> </ul> <p><b>Ask a doctor or pharmacist before use if you are taking sedatives or tranquilizers</b></p> <p><b>When using this product</b></p> <ul style="list-style-type: none"> <li>■ avoid alcoholic drinks</li> <li>■ marked drowsiness may occur</li> <li>■ excitability may occur, especially in children</li> <li>■ alcohol, sedatives and tranquilizers may increase drowsiness</li> <li>■ be careful when driving a motor vehicle or operating machinery</li> </ul> <p><b>If pregnant or breast-feeding,</b> ask a health professional before use.</p> <p><b>Keep out of reach of children.</b> In case of overdose, get medical help or contact a Poison Control Center right away.</p>							
<b>Directions</b>							
<ul style="list-style-type: none"> <li>■ if needed, take every 4-6 hours</li> <li>■ do not take more than 6 doses in 24 hours</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 50%;">children under 6 years of age</td> <td style="width: 50%;">ask a doctor</td> </tr> <tr> <td>children 6 to under 12 years of age</td> <td>1 to 2 teaspoonfuls (12.5 mg to 25 mg)</td> </tr> <tr> <td>adults and children 12 years of age and over</td> <td>2 to 4 teaspoonfuls (25 mg to 50 mg)</td> </tr> </tbody> </table>		children under 6 years of age	ask a doctor	children 6 to under 12 years of age	1 to 2 teaspoonfuls (12.5 mg to 25 mg)	adults and children 12 years of age and over	2 to 4 teaspoonfuls (25 mg to 50 mg)
children under 6 years of age	ask a doctor						
children 6 to under 12 years of age	1 to 2 teaspoonfuls (12.5 mg to 25 mg)						
adults and children 12 years of age and over	2 to 4 teaspoonfuls (25 mg to 50 mg)						

<b>Drug Facts</b> (continued)
<b>Other information</b>
<ul style="list-style-type: none"> <li>■ each teaspoonful contains: sodium 15 mg</li> <li>■ store at 20°-25°C (68°-77°F)</li> </ul>
<b>Inactive ingredients</b> citric acid, D&C red no. 33, FD&C red no. 40, flavor, glycerin, high fructose corn syrup, poloxamer 407, purified water, sodium benzoate, sodium chloride, sodium citrate, sorbitol



\*This product is not manufactured or distributed by Warner-Lambert Consumer Healthcare, distributor of Children's Benadryl®.

Using Handout 3.1 and the medication package above, answer these questions:

1. On the medication package, circle the undesired effects that Kristopher may get from the Diphedryl®.



Answer Key 3.1

2. About 30 minutes after giving Kristopher the medication, he is running around acting hyper and is having trouble calming down. What do you think is happening?

He may be having a side effect of the medication.

What should you do? Check Kristopher's Written Medication Consent Form for instructions from the health care provider (box 9 on the form). Contact his parent and encourage his parent to contact the doctor. You also need to write down on his Log of Medication Administration (in the Side Effects column) the side effect you saw and make a note that you contacted his parent.

## Exercise: Identifying Types of Medication ANSWER KEY



Directions: Answer the questions using the package or medication label.

### Example 1



**Infants' TYLENOL®**  
Acetaminophen Pain Reliever-Fever Reducer  
**NEW! SimpleMeasure™**

**See New Dosage & Directions**  
NDC 50980-191-01  
**Infants' TYLENOL®**  
For Children  
Acetaminophen Oral Suspension  
Pain Reliever-Fever Reducer

**INFANTS**  
**NEW! Dosage & Directions**

Ibuprofen Free  
Alcohol Free  
Aspirin Free

Use Only Enclosed Syringe  
**SimpleMeasure™**  
See side panel for more information

**Grape FLAVOR**  
1 fl oz (30 mL)  
160 mg per 5 mL

**Drug Facts (continued)**  
replace cap tightly to maintain child resistance  
Dosing Chart

Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL

\* or as directed by a doctor  
Attention: use only enclosed syringe specifically designed for use with this product. Do not use any other dosing device.

**Other information**  
store between 20-25°C (68-77°F)  
do not use if carbon tape imprinted "SAFETY SEAL" or bottle wrap imprints "SAFETY SEAL" and "USE WITH ENCLOSED DOSING DEVICE ONLY" is broken or missing  
see bottom panel for lot number and expiration date

**Inactive ingredients** anhydrous citric acid, butylparaben, D&C red #33, FD&C blue #1, flavors, glycerin, high fructose corn syrup, microcrystalline cellulose and carboxymethylcellulose sodium, propylene glycol, purified water, sodium benzoate, sorbitol solution, sucralose, xanthan gum

**Questions or comments?**  
call 1-877-895-3665

**Drug Facts**

Active ingredient (in each 5 mL)	Purpose
Acetaminophen 160 mg	Pain reliever/fever reducer

**Uses** temporarily relieves fever  
relieves minor aches and pains due to:  
the common cold flu headache sore throat toothache

**Warnings**  
Liver warning: This product contains acetaminophen. Severe liver damage may occur if your child takes more than 5 doses in 24 hours, which is the maximum daily amount  
with other drugs containing acetaminophen  
Sore throat warning: If sore throat is severe, persists for more than 2 days, is accompanied or followed by fever, headache, rash, nausea, or vomiting, consult a doctor promptly.

**Do not use**  
with any other drug containing acetaminophen (prescription or nonprescription). If you are not sure whether a drug contains acetaminophen, ask a doctor or pharmacist.  
if your child is allergic to acetaminophen or any of the inactive ingredients in this product  
Ask a doctor before use if your child has liver disease

Ask a doctor or pharmacist before use if your child is taking the blood thinning drug warfarin

When using this product do not exceed recommended dose (see overdose warning)

Stop use and ask a doctor if pain gets worse or lasts more than 5 days  
fever gets worse or lasts more than 3 days  
new symptoms occur redness or swelling is present  
These could be signs of a serious condition.

Keep out of reach of children. Overdose warning: Taking more than the recommended dose (overdose) may cause liver damage. In case of overdose, get medical help or contact a Poison Control Center right away. (1-800-222-1222) Quick medical attention is critical for adults as well as for children even if you do not notice any signs or symptoms.

**Directions**  
this product does not contain directions or complete warnings for adult use.  
do not give more than directed (see overdose warning)  
shake well before using  
mL = milliliter  
find right dose on chart. If possible, use weight to dose; otherwise, use age.  
push air out of syringe. Firmly push syringe into bottle opening  
turn bottle upside down and pull syringe to the correct dose  
dispense liquid slowly into child's mouth, toward inner cheek  
repeat dose every 4 hours while symptoms last  
do not give more than 5 times in 24 hours

**NEW! SimpleMeasure™**

**STEP 1.** See Directions for the correct dose for your child.

**STEP 2.** Shake well before using.

**STEP 3.** Push air out of syringe. Firmly push syringe into bottle opening.

**STEP 4.** Turn the bottle upside down and pull syringe to the correct dose.

**STEP 5.** Dispense liquid slowly into child's mouth.

**IMPORTANT:**  
New Dosage and Directions. Please see dosing chart or ask a doctor for your child's correct dose.

LOT: **ABC987**  
EXP: **09/XX**

- Is this medication over-the-counter or prescription? How can you tell?  
*Over-the-counter medication. There is no pharmacy label on it. The directions are not child-specific. You can buy it at the pharmacy without an order from a licensed authorized prescriber.*
- Is this medication a brand name or generic name medication? How can you tell?  
*Brand name. The package says Tylenol with the ® symbol after the name.*
- What is the active ingredient?  
*Acetaminophen*

**Example 2**

**Pharmacy Inc.** #0012 **Ph: 212-555-0102**  
100 Main Street, New York, NY 10068  
Rx#: 8145973-02 Tx: 8063264

**Michael Brown DOB: 06/04/XX**  
(718) 554-1984  
461 Park Place, Brooklyn, NY 11202

**EpiPen® Jr. (0.15 mg)**  
**administer one dose (0.15mg) via autoinjection as needed for signs of anaphylaxis including: difficulty breathing; difficulty swallowing; hives; loss of consciousness; severe vomiting, diarrhea or abdominal cramps.**

Prescriber: **Nancy Wallace MD (718) 564-9832**  
221 Stream Place, Brooklyn, NY 11202  
Refillable: 0 times QTY: 1 injector R.Ph. Init: RSL  
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. date: 7/15/XX

1. Is this medication over-the-counter or prescription? How can you tell?

*Prescription. The medication package has a pharmacy label, which is for a specific child, Michael Brown.*

2. Is this medication a brand name or generic name medication? How can you tell?

*Brand name. The medication name, EpiPen, has the ® symbol after it.*

## What Permissions and Instructions Do I Need to Give Medication?



All child care providers can give the following with written permission from the parent:

- Sunscreen
- Topically applied insect repellent
- Over-the-counter topical ointments (This includes ointments, creams, gels and lotions.)

The OCFS-6010 *Non-Medication Consent Form* is available to use for this purpose only. See the OCFS website ([www.ocfs.ny.gov/main/documents/docsChildCare.asp](http://www.ocfs.ny.gov/main/documents/docsChildCare.asp)). If the package directions indicate to consult a doctor, or if the instructions provided by the parent do not match the label instructions, you need written instructions from the child's health care provider before you can give it.

You must have **written** permission from the parent and **written** instructions from the child's health care provider to give any medication.

- The permission and instructions must be written in a language in which you can read and write.
- Parents and health care providers must renew the written permission and instructions at least once every six months for children under the age of five (5) years, and once per year for children five (5) years and older.
- You can accept faxed consents for written permission and instructions.
- All written permission and instructions should be provided on the OCFS *Written Medication Consent Form* or an approved equivalent.

**Your program's Health Care Plan outlines the policies and procedures that you *must* follow when administering medication. Check your program's health care plan to see:**

- If your program has created its own permission and instructions form.
- If you can accept written permission and instructions not provided on a preapproved equivalent of the OCFS *Written Medication Consent Form*. Written information needs to include:
  - ◆ Child's first and last name
  - ◆ Date of birth
  - ◆ Known allergies (KA)
  - ◆ Medication name (including strength)
  - ◆ Medication dosage
  - ◆ Route of administration
  - ◆ How often to give medication, or what symptoms child must exhibit that necessitate administering the medication

*continued on next page ►*

- ◆ Possible side effects and/or additional side effects
- ◆ Actions to take if side effects are observed
- ◆ Special instructions via package insert and/or additional special instructions
- ◆ Reason the child is taking the medication (unless confidential by law)
- ◆ Does the child have a Special Health Care Need according to OCFS' definition?
- ◆ Is this a change from a previous medication order?
- ◆ Date prescriber authorized
- ◆ Date to be discontinued
- ◆ Prescriber name, telephone number and licensed authorized prescriber's signature

### ***Permission and Instructions Exceptions***

If your health care plan permits, you may accept verbal permission in the following circumstances:

1. For children less than eighteen (18) months of age, prescription medication, oral over-the-counter medication, medicated patches, and eye, ear, or nasal drops or sprays, can be administered by a caregiver for one day only, *with verbal permission of the parent and verbal instructions directly from the health care provider or licensed authorized prescriber*. If prescription medication, oral over-the-counter medication, medicated patches, and eye, ear, or nasal drops or sprays are to be administered on a subsequent day or on an ongoing basis, written permission from the parent and written instructions from the health care provider must have been provided to the caregiver prior to such administration.
2. For children eighteen (18) months of age and older, prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays, can be administered by a caregiver *for one day only, with the verbal permission of the parent*.

A caregiver cannot administer medication to any child in care if the parent's instructions differ from the instructions on the medication packaging, until the child care provider receives permission from a health care provider or licensed authorized prescriber on how to administer the medication.

- The caregiver must immediately notify the parent if the caregiver will not administer medication due to differing instructions related to the administration of medication.

### ***Accepting Verbal Instructions:***

Check your program's health care plan to see if you can accept verbal permission and instructions. If you accept verbal permission and instructions, use the OCFS *Verbal Medication Consent Form and Log of Administration* and write down all of the doses you give the child for that day only.

You may only accept verbal instructions from a physician, physician assistant, nurse practitioner, or registered nurse on behalf of the child's physician, physician assistant or nurse practitioner. See Handout 4.6.

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:
4. Name of Medication ( <i>including strength</i> ):	5. Amount/Dosage to be Given:	6. Route of Administration:
7A. Frequency to be administered: _____		
<b>OR</b>		
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )		
<b>AND/OR</b>		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )		
<b>AND/OR</b>		
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____		
11. Reason for medication ( <i>unless confidential by law</i> ): _____		
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? <input type="checkbox"/> No <input type="checkbox"/> Yes    If you checked yes, complete (#33 and #35) 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? <input type="checkbox"/> No <input type="checkbox"/> Yes    If you checked yes, complete (#34 -#35) on the back of this form.		
14. Date Health Care Provider Authorized:	15. Date to be Discontinued or Length of Time in Days to be Given:	
16. Licensed Authorized Prescriber's Name (please print):		17. Licensed Authorized Prescriber's Telephone Number:
18. Licensed Authorized Prescriber's Signature: <b>X</b>		

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

**PARENT 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 licensed authorized prescriber write 12pm?*)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (*i.e.: 12 pm*): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (*child's name*): \_\_\_\_\_

21. Parent's Name (*please print*): \_\_\_\_\_

22. Date Authorized: \_\_\_\_\_

23. Parent's Signature: \_\_\_\_\_

**X**

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

24. Program Name: \_\_\_\_\_

25. Facility ID Number: \_\_\_\_\_

26. Program Telephone Number: \_\_\_\_\_

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 day care program.

28. Staff's Name (*please print*): \_\_\_\_\_

29. Date Received from Parent: \_\_\_\_\_

30. Staff Signature: \_\_\_\_\_

**X**

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature: \_\_\_\_\_

**X**

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature: \_\_\_\_\_

**X**

## Common Medical Abbreviations



Abbreviation	Meaning
$\bar{a}$	before
$\bar{ac}$	before meals
bid, BID	twice a day
$\bar{c}$	with
cc	cubic centimeter
dc'd	discontinued, stopped
gtt	drop
Gm, gm, g	gram
hr, H	hour
hs, HS	bedtime (hour of sleep)
kg	kilogram
mcg	micrograms
mg	milligram
ml	milliliter
NKA	no known allergies
NKDA	no known documented allergies
OD	right eye
OS	left eye
OU	each eye
$\bar{oz}$	ounce
$\bar{p}$	after, past
pc	after meals
per	by
po	by mouth
prn	as needed
Q	every
qd	every day
qid, QID	four times a day
$\bar{qod}$ , QOD	every other day
$\bar{s}$	without
i	one
ii	two
iii	three
tbsp., T	tablespoon
tid, TID	three times a day
tsp, t	teaspoon

*Medication instructions should be spelled out, and abbreviations should not be used. If you do not understand anything that is stated on the medication consent form, you must receive clear instructions before you can administer the medication.*



*This page is intentionally blank.*

OCFS-LDSS-7004 (5/2014) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**LOG OF MEDICATION ADMINISTRATION**

- Caregivers may use this form or an approved equivalent to document medications administered in the day care program.
- Documentation must be kept with the child's written medication consent form.
- Any doses of the medication listed below not given must be documented.

CHILD NAME:

MEDICATION:(including dose)

COMPLETE FOR ALL DOSES GIVEN				COMPLETE WHEN SIDE EFFECTS ARE NOTED		COMPLETE FOR 'AS NEEDED' MEDICATION ONLY	
Date Given (M/D/Y)	Dose	Time (AM or PM)	Administered by (full signature)	Any Noted Side Effects	Were parents notified of side effects?	For "as needed" medication – write the symptoms the child exhibited that necessitated the need for the medication	Were parents notified "as needed" medicine was given
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
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		<input type="checkbox"/> AM <input type="checkbox"/> PM			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No



## Good Documentation



You must keep a record of all medication given at your program. When you write down all of the medication you give in your program, you help prevent medication errors, including a child missing a dose of medication or a child accidentally receiving two doses.

### Here are some tips for good documentation:

- Use one *Log of Medication Administration* for each medication the child is taking.
- Write in ink.
- Write down all medication you give immediately after the child takes it.
- Always document the date and dose you gave, what time you gave it, and sign the log.
- If you gave an “as needed” medication, be sure to write down why you gave the medication and whether or not you notified the child’s parent.
- Write down in the child’s log any side effects you observe and that you notified the child’s parent.
- If a medication was not given, write down the reason why.
- Write down any medication the child received at home before arriving in your care.
- If a family member came to your program to give the child medication, you must write down who gave the medication, the dose and the time it was given by the family member.
- If you make an error when writing down the medication you gave the child, cross out the incorrect information with a single line and write “error” with your initials next to it, then write the correct information.  
e.g., Dose: ~~Two drops~~ Error MW  
Dose: One drop
- DO NOT use correction fluid.



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OCFS-LDSS-7003 (5/2014) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**VERBAL MEDICATION CONSENT FORM AND LOG OF ADMINISTRATION**

Caregivers may use this form or an approved equivalent to document that a parent requested that a medication be given, but did not have written instructions from the authorized prescriber.

**The medication authorized on this form is valid for one day only. This consent form does not authorize the administration of the medication listed below on multiple days.**

1. Child's first and last name:	2. Name of medication (including strength):	3. Amount/dosage to be given:
---------------------------------	---	-------------------------------

4. Route of administration:	5. Frequency to be administered for today only:
-----------------------------	---

6A. Possible side effects:  See package insert for complete list of possible side effects (must be obtained from medication package or insert)

**AND/OR**

6B: Additional side effects:

7. What action should the program take if side effects are noted:

- Contact parent
- Contact prescriber at phone number provided
- Other (describe): \_\_\_\_\_

8A. Special instructions:  See package insert for complete list of special instructions (must be obtained from medication package or insert)

**AND/OR**

8B. 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.)

9. Provider name:	10. License/ Registration number:	11. Program telephone number:
-------------------	-----------------------------------	-------------------------------

12. I, \_\_\_\_\_ received verbal permission from \_\_\_\_\_

(name of caregiver) (child's parent)

to administer the medication listed above on \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

(date authorized to)

The instructions I received from the parent match the instructions for use on the medication container. If the instructions do not match, I received verbal or written instructions from the health care provider or licensed authorized prescriber.

OCFS-LDSS-7003 (5/2014) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**VERBAL MEDICATION CONSENT FORM AND LOG OF ADMINISTRATION**

13. COMPLETE THIS SECTION FOR VERBAL MEDICATION CONSENTS REQUIRING HEALTH CARE PROVIDER INSTRUCTIONS

In addition to the above parent consent I, \_\_\_\_\_ received verbal instructions from \_\_\_\_\_  
(name of caregiver)  
*(check the box below to indicate credentials of person )*

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Registered Nurse on behalf of the child's physician, PA or NP

to administer the medication listed above on \_\_\_\_\_  
(date authorized to give)

A request was made to have the health care provider send the medication instructions in writing.

14. Licensed prescriber's name (physician, PA or NP):	15. Licensed prescriber's telephone number:
16. I have verified that sections #1 - #15 are complete. My signature indicates that all information necessary to safely administer this medication has been given to the child care program.	
17. Caregiver's name (please print):	18. Date received:
19. Caregiver's signature: <b>X</b>	

Date Given	Medication	Dose	Time Given	Caretaker Signature

**PARENT ACKNOWLEDGEMENT OF VERBAL CONSENT**

I, parent, gave verbal permission to the child care program to administer the above indicated medication on _____ (date)
Parent's Signature: <b>X</b>

## Medication Storage



When deciding where to keep medication, make sure the area you choose in your program is:

### **General Medication**

- A clean and secure place that children cannot get to (inaccessible).
- A cool, dry and dark place, unless the directions state something else.

### **Emergency Medication**

- In an area near the child where you can get it quickly.
- You may decide if the best place is:
  - ◆ in your emergency bag; or
  - ◆ in a pack that you wear.

Your health care plan will state where you will keep medication in your program. You may have a couple of places. ***If you change the area where you keep medication, you must update your health care plan.***

### **Refrigerated Medication**

- If you keep medication in your food refrigerator, you need to keep it separate from food and it must also be kept in a leakproof container. A leakproof container is a container that when turned over and shaken does not allow any liquid to escape.
- If you have a separate refrigerator you use for medication only, make sure the refrigerator is locked or is inaccessible to children.
- Keep the refrigerator at a temperature between 36 - 46° F.
- If your program has a power outage or your refrigerator stops working, call your local pharmacy and follow their recommendations regarding the use of the medication kept in the refrigerator.

### **Controlled Substances**

- Store in a locked area with limited access.
- Always count the number of pills or note the amount of liquid in the bottle when receiving from a parent.
- Keep a running count each day if more than one staff member is giving the medication or has access to the storage area.
- Count the number of pills or note the amount of liquid left in the bottle when giving the medication back to the parent.

### **Medication Disposal**

Always return medication to the parent when medication has expired, has been discontinued or if the consent has expired.

If you are unable to return the medication to the parent, follow these guidelines:

- Take the medication out of its original container.
- Mix the medication with an undesirable substance, such as coffee grounds or kitty litter. The American Pharmaceutical Association recommends first crushing or dissolving the medication in water.
- Place the material in a leakproof container, such as an empty can or a sealed plastic bag.
- Throw the container in the trash.
- Flush medication down the toilet only if the medication package or insert states it is safe to do so.

### **Stock Medication**

Your program may keep a supply of certain over-the-counter medication that is not labeled for a specific child to have available for use if a child needs it while in care. You will follow the same guidelines to store stock medication as you follow to store medication for a specific child.

Programs that participate in the New York State Department of Health's Fluoride Program can stock non-child-specific fluoride tablets supplied by DOH.

Child care programs that store and administer medication that is not labeled for a specific child must have an over-the-counter stock medication policy in place before beginning to store any over-the-counter medication. The over-the-counter stock medication policy must address the safe storage and proper administration of the stored over-the-counter medication and must address the need for strict infection control practices as they pertain to stock medication.

- Stock medication must be kept in a clean area that is inaccessible to children, and any stock medication must be stored separate from child-specific medication.
- Stock medication must be kept in the original container and have the following information on the label or in the package insert:
  - Name of the medication;
  - Reason(s) for use;
  - Directions for use, including route of administration;
  - Dosage instructions;
  - Possible side effects and/or adverse reactions;
  - Warnings or conditions under which it is inadvisable to administer the medication; and
  - Expiration date.



Handout 4.7

- Child care programs that stock supplies of over-the-counter medication, which are not in single-dose packaging, must provide a separate mechanism to administer the medication for each child that may need the medication.
- Once a device has been used for a specific child in care, that specific device must be disposed of or reused only for that specific child and must be labeled with the child's first and last name.
- The program must include the procedure in the over-the-counter stock medication policy for dispensing the stock medication from the container to the device, or directly administering to the child, without contaminating the stock medication.
- All stock medication must be administered using best practice techniques in accordance with the directions for use on the medication package.
- Child day care programs may not stock prescription medication.



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## Accepting Medication



Follow the steps below whenever you receive medication from a parent. If you are not able to complete the step, tell the parent you cannot accept the medication and discuss what you need the parent to do so that you can give the medication.

Complete the Following Steps	 for Each Completed Step
1. The medication is labeled with the child's full name. <ul style="list-style-type: none"> <li>For prescription medication, the pharmacy label is attached to the container and is readable. If needed, the parent also gives you any special tools, such as a dosing spoon or oral syringe, with the child's first and last names written on it. See Handout 4.9.</li> </ul>	
2. The expiration date is on the medication package and the medication has not expired.	
3. You have written instructions from the health care provider. <ul style="list-style-type: none"> <li>The instructions are complete, understandable and signed by the health care provider.</li> <li>If the health care provider did not write a specific time, such as 1:00PM, in Box 7A, make sure the parent writes the specific time to give the medication in Box 19.</li> <li>See Handout 4.1 for what to do if the parent does not have written instructions.</li> </ul>	
4. You have written permission from the parent. <ul style="list-style-type: none"> <li>See Handout 4.1 for what to do if the parent is not able to sign the form.</li> </ul>	
5. The instructions written on the medication label and package match the instructions on the <i>Written Medication Consent Form</i> . <ul style="list-style-type: none"> <li>See Handout 4.10 for more information if the label does not match.</li> </ul>	
6. Fill out the Day Care Program section on the <i>Written Medication Consent Form</i> and tell the parent you are agreeing to give the medication.	
7. Put the medication in the medication storage area or refrigerator. <ul style="list-style-type: none"> <li>Make sure this is the storage area you wrote in your health care plan.</li> </ul>	

Table continued on next page ►

Complete the Following Steps	 for Each Completed Step
<i>(Table continued from previous page)</i>	
8. Create a <i>Log of Medication Administration</i> for the child's medication.	
9. File the <i>Written Medication Consent Form</i> , any package inserts or pharmacy printouts and the <i>Log of Medication Administration</i> together in a place where you will be able to review the forms each day.	

## Administration Tools and Medication Label Requirements



### **Over-the-Counter Medication Label Requirements**

Over-the-counter medication must be in its original container and must be labeled with the child's first and last names.

### **Prescription Medication Label Requirements**

Prescription medication should be in a child-resistant container. It must have the original pharmacy label that includes the following:

1. Child's first and last names
2. Medication name
3. How often to give the medication
4. Medication dose
5. Date to stop giving the medication (discontinue date) or number of days to give the medication—if applicable
6. Health care provider's name who prescribed the medication
7. Pharmacy name and telephone number
8. Date prescription was filled

<b>7</b>	<b>Pharmacy Inc. #0012 Ph: 212-555-0102</b> 100 Main Street, New York, NY 10068 Rx#: 8145974-02 Tx: 8063264	
<b>1</b>	<b>Jose Martinez DOB: 11/30/XX</b> (718) 554-1984 461 Park Place, Brooklyn, NY 11202	
<b>2</b>	<b>Amoxicilin 250mg Tabs</b>	
<b>4</b>	<b>3</b>	<b>5</b>
	<b>Give one tablet by mouth at 10AM and 2PM. Discontinue after 14 days.</b>	
<b>6</b>	<b>Prescriber: Nancy Wallace MD (718) 564-9832</b> 221 Stream Place, Brooklyn, NY 11202 Refillable: 0 times QTY: 30 R.Ph. Init: RSL	
<b>8</b>	<b>Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/XX</b>	

### **Sample Medication**

Medication samples are not dispensed by a pharmacy and will not have a pharmacy label. Medication samples supplied by the child's health care provider must be appropriately labeled with the same information that is required on a pharmacy label. Parents should be aware of this requirement so the child's health care provider can label the samples with the required information.



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## Medication Label Does Not Match Consent Form



The information written on the medication label must exactly match the information written on the child's *Written Medication Consent Form*.

However, for changes in the instructions, you can give medication in its originally labeled bottle when the only changes made by the health care provider are:

- dose; and
- time and/or frequency.

If you accept changes in dose, time, and/or frequency, your program needs to let the staff approved to give medication know, both verbally and in writing, that the instructions on the pharmacy label do not match the instructions the health care provider has written.

One way to do this is to put a colored sticker on the child's medication near the pharmacy label. That way you will know that any child's pharmacy label marked with a sticker does not have the updated information and you should follow the instructions on the child's *Written Medication Consent Form*.

In addition, the health care provider must write on the consent form the date when (s)he is ordering the change in the administration of the prescription medication to take effect.



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## Planning Your Day



Each day, before children arrive in your program, you'll need to plan for the medication needs of children in your program. Follow these tips to plan your day.

- Review each current *Written Medication Consent Form* for the following:
  - ◆ The time the medication is due
  - ◆ The symptoms to look for if the medication is “as needed” medication
  - ◆ The expiration date to make sure the consent is not expired
- Check each medication's expiration date, including any stock medication.
- Check how much medication is left so you can let parents know when your supply is getting low.
- Decide where you will give medication. A safe area should be:
  - ◆ well lit;
  - ◆ where you can provide adequate supervision when giving the medication;
  - ◆ near all of the supplies you need to give the medication, like paper towels and gloves; and
  - ◆ clean before you give medication.

You'll also need to be flexible once the children arrive at your program, since you may need to change your plan.

You may find out information when children arrive at your program:

- Medication may have been taken before coming to your program.
- New medication may be needed.
- Medication doses may change or be discontinued.



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## Exercise: Accepting Medication



### Directions:

Pair up with another participant. Using your handouts, read each case study and answer the questions.

**Case Study 1:** Carly McMahon is a ten-month-old child in your program. When her mother drops her off, she tells you Carly is teething and is uncomfortable and irritable. She also says she spoke with Carly's doctor last night and the doctor recommended she give her Tylenol® for the pain. Her mother gives you a bottle of Infants' Tylenol Oral Suspension with Carly's name on it and asks you to give her a dose at 1PM today. She does not have a completed *Written Medication Consent Form* signed by Carly's health care provider.



**Infants' TYLENOL®**  
Carly McMahon  
NEW! SimpleMeasure™

See New Dosage & Directions  
NDC 50380-191-01  
**Infants' TYLENOL®**  
For Children  
Acetaminophen Oral Suspension  
Pain Reliever-Fever Reducer

**NEW! Dosage & Directions**

ibuprofen Free  
Alcohol Free  
Aspirin Free

Use Only Enclosed Syringe  
**SimpleMeasure™**  
See side panel for more information

**Grape** FLAVOR  
1 fl oz (30 ml)  
160 mg per 5 ml

**Drug Facts (continued)**  
● replace cap tightly to maintain child resistance  
Dosing Chart

Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL

\* or as directed by a doctor  
Attention: use only enclosed syringe specifically designed for use with this product. Do not use any other dosing device.

**Other information**  
● store between 20-25°C (68-77°F)  
● do not use if carbon tape is printed  
● SAFETY SEAL® or bottle wrap imprint  
● SAFETY SEAL® and USE WITH ENCLOSED DOSING DEVICE ONLY is broken or missing  
● see bottom panel for lot number and expiration date

**Inactive ingredients** anhydrous citric acid, butylparaben, D&C red #33, FD&C blue #1, flavors, glycerin, high fructose corn syrup, microcrystalline cellulose and croscarmellose sodium, propylene glycol, purified water, sodium benzoate, sorbitol solution, sucralose, xanthan gum

**Questions or comments?**  
call 1-877-985-3665

**Drug Facts**

Active ingredient (in each 5 mL)	Purpose
Acetaminophen 160 mg	Pain reliever/fever reducer

**Uses temporarily**  
● induces fever  
● relieves minor aches and pains due to:  
● the common cold ● flu ● headache ● sore throat ● toothache

**Warnings**  
Liver warning: This product contains acetaminophen. Severe liver damage may occur if your child takes more than 5 doses in 24 hours, which is the maximum daily amount.  
● with other drugs containing acetaminophen  
Sore throat warning: If sore throat is severe, persists for more than 2 days, is accompanied or followed by fever, headache, rash, nausea, or vomiting, consult a doctor promptly.

**Do not use**  
● with any other drug containing acetaminophen (prescription or nonprescription). If you are not sure whether a drug contains acetaminophen, ask a doctor or pharmacist.  
● if your child is allergic to acetaminophen or any of the inactive ingredients in this product

**Ask a doctor before use if your child has liver disease**  
**Ask a doctor or pharmacist before use if your child is taking the blood thinning drug warfarin**

**When using this product do not exceed recommended dose (see overdose warning)**  
**Stop use and ask a doctor if**  
● pain gets worse or lasts more than 5 days  
● fever gets worse or lasts more than 3 days  
● new symptoms occur ● rash or swelling is present  
These could be signs of a serious condition.

**Keep out of reach of children. Overdose warning:** Taking more than the recommended dose (overdose) may cause liver damage. In case of overdose, get medical help or contact a Poison Control Center right away. (1-800-222-1222) Quick medical attention is critical for adults as well as for children even if you do not notice any signs or symptoms.

**Directions**  
● this product does not contain directions or complete warnings for adult use.  
● do not give more than directed (see overdose warning)  
● shake well before using  
● mL = milliliter  
● find right dose on chart. If possible, use weight to dose; otherwise, use age.  
● push air out of syringe. Firmly push syringe into bottle opening.  
● turn bottle upside down and pull syringe to the correct dose.  
● dispense liquid slowly into child's mouth, toward inner cheek  
● repeat dose every 4 hours while symptoms last  
● do not give more than 5 times in 24 hours

**STEP 1.** See *Directions* for the correct dose for your child.  
**STEP 2.** Shake well before using.  
**STEP 3.** Push air out of syringe. Firmly push syringe into bottle opening.  
**STEP 4.** Turn the bottle upside down and pull syringe to the correct dose.  
**STEP 5.** Dispense liquid slowly into child's mouth.

**IMPORTANT:**  
New Dosage and Directions. Please see dosing chart or ask a doctor for your child's correct dose.

LOT: **ABC987**  
EXP: **09/XX**

1. Do you have the required instructions from Carly's doctor to accept the medication? How do you determine this?

If not, is there anything you can do so you can accept the medication from Carly's mother?

**Case Study 2:** Joshua Liebowitz is a four-year-old child in your program. You have been giving him a medication called carbamazepine (CAR-buh-MAZ-uh-peen) every day at 12PM for the last nine months to prevent seizures. He has been doing very well and has not had a seizure since taking the medication. Today, Joshua's father drops him off and tells you Joshua's doctor wants to lower the amount of the carbamazepine Joshua takes. Joshua's father gives you new written instructions from the doctor (see next page) but does not have a new bottle of medicine, since there is still plenty of medicine left and the pharmacy won't fill a new prescription yet.

1. Do you have the required instructions from Joshua's doctor to accept the medication?
  
2. You see that Box 13 is checked on Joshua's consent form. The label on the carbamazepine bottle you have stored at the program does not match the dose written on the consent form. Do you need a new medication label that matches the new written health care provider instructions before you agree to give the medication?

What else do you need to do?

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: Joshua Liebowitz		2. Date of Birth: 2/6/XXXX (4 years old)		3. Child's Known Allergies: None	
4. Name of Medication ( <i>including strength</i> ): Carbamazepine suspension (100mg/5ml)			5. Amount/Dosage to be Given: 1 tsp		6. Route of Administration: oral
7A. Frequency to be administered: 12 noon					
<b>OR</b>					
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): _____					
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )					
<b>AND/OR</b>					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____					
10A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )					
<b>AND/OR</b>					
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____					
11. Reason for medication ( <i>unless confidential by law</i> ): seizure disorder					
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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.					
14. Date Health Care Provider Authorized: 10/13/XXXX			15. Date to be Discontinued or Length of Time in Days to be Given: 4/13/XXXX		
16. Licensed Authorized Prescriber's Name (please print): Gary Marchione, MD				17. Licensed Authorized Prescriber's Telephone Number: (914) 555-1998	
18. Licensed Authorized Prescriber's Signature: X <i>Gary Marchione</i>					

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
CHILD DAY CARE PROGRAMS

**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):  
Joshua Liebowitz

21. Parent's Name (please print):  
Gabriel Liebowitz

22. Date Authorized:  
10/14/XXXX

23. Parent's Signature:

X *Gabriel Liebowitz*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (please print):  
Carla Carson

29. Date Received from Parent:  
10/14/XXXX

30. Staff Signature:

X *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.  
See Individual Health Care Plan

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: 10/13/XXXX

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X *Gary Marchione*

## Exercise: Accepting Medication ANSWER KEY



**Case Study 1:** Carly McMahon is a ten-month-old child in your program. When her mother drops her off, she tells you Carly is teething and is uncomfortable and irritable. She also says she spoke with Carly's doctor last night and the doctor recommended she give her Tylenol® for the pain. Her mother gives you a bottle of Infants' Tylenol Oral Suspension with Carly's name on it and asks you to give her a dose at 1PM today. She does not have a completed *Written Medication Consent Form* signed by Carly's health care provider.



**Drug Facts (continued)**

- replace cap tightly to maintain child resistance

Dosing Chart		
Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL

\* or as directed by a doctor  
**Attention:** use only enclosed syringe specifically designed for use with this product. Do not use any other dosing device.

**Other information**

- store between 20-25°C (68-77°F)
- do not use if carbon tape imprinted "SAFETY SEAL" or bottle wrap imprinted "SAFETY SEAL" and "USE WITH ENCLOSED DOSING DEVICE ONLY" is broken or missing
- see bottom panel for lot number and expiration date

**Inactive ingredients** anhydrous citric acid, butylparaben, D&C red #53, FD&C blue #1, flavors, glycerin, high fructose corn syrup, microcrystalline cellulose and carboxymethylcellulose sodium, propylene glycol, purified water, sodium benzoate, sorbitol solution, sucralose, xanthan gum

**Questions or comments?**  
 call 1-877-485-3665

**See New Dosage & Directions**

NDX 50580-191-01

# Infants' TYLENOL®

For Children

## Acetaminophen Oral Suspension

Pain Reliever-Fever Reducer

**NEW! Dosage & Directions**

ibuprofen Free  
 Alcohol Free  
 Aspirin Free

Use Only Enclosed Syringe

**SimpleMeasure™**

1 fl oz (30 mL)  
 160 mg per 5 mL

**NEW! SimpleMeasure™**

**STEP 1.** See *Directions* for the correct dose for your child.

**STEP 2.** Shake well before using.

**STEP 3.** Push air out of syringe. Firmly push syringe into bottle opening.

**STEP 4.** Turn the bottle upside down and pull syringe to the correct dose.

**STEP 5.** Dispense liquid slowly into child's mouth.

**IMPORTANT:**  
 New Dosage and Directions. Please see dosing chart or ask a doctor for your child's correct dose.

Active ingredient (in each 5 mL)	Purpose
Acetaminophen 160 mg	Pain reliever/fever reducer

**Uses** temporarily: ■ reduces fever  
 ■ relieves minor aches and pains due to:  
 ■ the common cold ■ flu ■ headache ■ sore throat ■ toothache

**Warnings**

**Liver warning:** This product contains acetaminophen. Severe liver damage may occur if your child takes ■ more than 5 doses in 24 hours, which is the maximum daily amount

■ with other drugs containing acetaminophen

**Sore throat warning:** If sore throat is severe, persists for more than 2 days, is accompanied or followed by fever, headache, rash, nausea, or vomiting, consult a doctor promptly.

**Do not use**

- with any other drug containing acetaminophen (prescription or nonprescription). If you are not sure whether a drug contains acetaminophen, ask a doctor or pharmacist.
- if your child is allergic to acetaminophen or any of the inactive ingredients in this product

**Ask a doctor before use if your child has liver disease**

**Ask a doctor or pharmacist before use if your child is taking the blood thinning drug warfarin**

**When using this product do not exceed recommended dose (see overdose warning)**

**Stop use and ask a doctor if** ■ pain gets worse or lasts more than 5 days  
 ■ fever gets worse or lasts more than 5 days  
 ■ new symptoms occur ■ redness or swelling is present  
 These could be signs of a serious condition.

**Keep out of reach of children. Overdose warning:** Taking more than the recommended dose (overdose) may cause liver damage. In case of overdose, get medical help or contact a Poison Control Center right away. (1-800-232-1222) Quick medical attention is critical for adults as well as for children when if you do not notice any signs or symptoms.

**Directions**

- this product does not contain directions or complete warnings for adult use.
- do not give more than directed (see overdose warning)
- shake well before using
- mL = milliliter
- fill right dose on chart. If possible, use weight to dose; otherwise, use age.
- push air out of syringe. Firmly push syringe into bottle opening
- turn bottle upside down and pull syringe to the correct dose
- dispense liquid slowly into child's mouth, toward inner cheek
- repeat dose every 4 hours while symptoms last
- do not give more than 5 times in 24 hours

LOT: **ABC987**  
 EXP: **09/XX**

1. Do you have the required instructions from Carly's doctor to accept the medication? How do you determine this?

*No. To administer OTC medication to a child under 18 months of age, you need to obtain and document verbal permission from the parent and verbal instructions from the child's health care provider.*

If not, is there anything you can do so you can accept the medication from Carly's mother?

*Yes. Document that you received verbal permission from the mother and obtain and document verbal instructions from the child's health care provider.*



Answer Key 4.1

**Case Study 2:** Joshua Liebowitz is a four-year-old child in your program. You have been giving him a medication called carbamazepine every day at 12PM for the last nine months to prevent seizures. He has been doing very well and has not had a seizure since taking the medication. Today, Joshua's father drops him off and tells you Joshua's doctor wants to lower the amount of the carbamazepine Joshua takes. Joshua's father gives you new written instructions from the doctor (see next page) but does not have a new bottle of medicine, since there is still plenty of medicine left and the pharmacy won't fill a new prescription yet.

1. Do you have the required instructions from Joshua's doctor to accept the medication?

Yes.

2. You see that Box 13 is checked on Joshua's consent form. The label on the carbamazepine bottle you have stored at the program does not match the dose written on the consent form. Do you need a new medication label that matches the new written health care provider instructions before you agree to give the medication?

No.

What else do you need to do?

*Notify (verbally and in writing) all staff who are approved to administer medication that the instructions on the pharmacy label do not match the health care provider's instructions.*

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: Joshua Liebowitz		2. Date of Birth: 2/6/XXXX (4 years old)		3. Child's Known Allergies: None	
4. Name of Medication ( <i>including strength</i> ): Carbamazepine suspension (100mg/5ml)			5. Amount/Dosage to be Given: 1 tsp		6. Route of Administration: oral
7A. Frequency to be administered: 12 noon					
<b>OR</b>					
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): _____					
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )					
<b>AND/OR</b>					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted:					
<input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below					
<input type="checkbox"/> Other ( <i>describe</i> ): _____					
10A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )					
<b>AND/OR</b>					
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____					
11. Reason for medication ( <i>unless confidential by law</i> ): seizure disorder					
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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.					
14. Date Health Care Provider Authorized: 10/13/XXXX			15. Date to be Discontinued or Length of Time in Days to be Given: 4/13/XXXX		
16. Licensed Authorized Prescriber's Name (please print): Gary Marchione, MD			17. Licensed Authorized Prescriber's Telephone Number: (914) 555-1998		
18. Licensed Authorized Prescriber's Signature: X <i>Gary Marchione</i>					

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
CHILD DAY CARE PROGRAMS

**PARENT 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 licensed authorized prescriber write 12pm?*)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (*i.e.: 12 pm*): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (*child's name*):  
Joshua Liebowitz

21. Parent's Name ( <i>please print</i> ): Gabriel Liebowitz	22. Date Authorized: 10/14/XXXX
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23. Parent's Signature:  
X *Gabriel Liebowitz*

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

24. Program Name: ABC Child Care	25. Facility ID Number: 01376 DCC	26. Program Telephone Number: (212) 555-8363
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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 day care program.

28. Staff's Name ( <i>please print</i> ): Carla Carson	29. Date Received from Parent: 10/14/XXXX
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30. Staff Signature:  
X *Carla Carson*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:  
X

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.  
See Individual Health Care Plan

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34. 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 you are ordering the change in the administration of the prescription to take place.  
DATE: 10/13/XXXX

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:  
X *Gary Marchione*

## Giving Medication to Children



You know the personalities of the children in your program. Use this knowledge when you give medication to help keep the process safe.

### **General Principles of Medication Administration**

When giving medication:

- Always act confidently and let the child know you expect cooperation.
- After giving the medication, thank the child.
- Remember, what works for one child may not always work with another, so be flexible.
- Talk to parents about how they get their child to take medication and try to follow the same routine when possible.



Sometimes you cannot safely get a child to take medication.

- **Never yell at, threaten or restrain a child in any way in order to get her to cooperate.** Never force a crying child to take medication.
- If you cannot give the medication safely to the child, call the child's parent.
- Remember to write down why you didn't give the medication in the child's log.

Here are some tips for safely giving medication to the children in your program:

#### **Infants**

- ☺ Talk in a calm, soothing voice.
- ☺ Listen to relaxing music.
- ☺ Rock the baby before and after giving any medication.
- ☺ Give medicine prior to a feeding, unless the health care provider's instructions specifically state to not give before a feeding.
- ☺ Don't add to formula or breast milk.

#### **Toddlers**

- ☺ Use age-appropriate language.
- ☺ Never call medicine "candy" or "candy-flavored" (e.g., pink amoxicillin "bubble gum" flavored medicine)
- ☺ Let the child cuddle a toy.
- ☺ Give the toddler some control, such as, "What color cup do you want to use?"
- ☺ Practice giving medicine to a doll or stuffed animal.
- ☺ Plan for time before and after giving the medication to soothe the child.

**Preschoolers**

- ☺ Prepare the child to take the medication.
- ☺ Have the child think about a favorite place or thing to do while taking the medication.
- ☺ Give a choice, such as, “What do you want to play with after?”

**School Age Children**

- ☺ Prepare the child to take the medication.
- ☺ Help the child relax by having her imagine a favorite place or take deep breaths.
- ☺ Have the child take an active role in the medication-taking process.
- ☺ Give as much control as possible.
- ☺ Allow the child to express feelings about having to take the medication.

## Special Situations



Once you have accepted responsibility to give medication to a child in your program, you must give it as instructed. However, there may be times when the child is in your program and you are not able to give the medication safely. There is a section on the back of the *Log of Medication Administration* for you to write down when you do not give the dose as instructed.

▶ **If the child refuses or you cannot safely give the medication:**

- ◆ Do not force the child to take the medication.
- ◆ Notify the child's parent immediately.
- ◆ Write in the child's log that the dose was not given and the reason why.
- ◆ Look at your program's health care plan for any additional actions.

▶ **If the child spits up (or vomits) immediately or soon after getting medication:**

- ◆ Do not administer the dose again.
- ◆ Notify the child's parent as soon as possible and report what happened.
- ◆ Write in the child's log that the child spit up (or vomited) some of the medication.

▶ **If the child is absent or is not scheduled to be in your program:**

- ◆ You do not need to write this in the child's *Log of Medication Administration*, since this is not a missed dose.

▶ **If you run out of medication and the parent has not given you a new supply:**

- ◆ Write in the child's log that you were not able to give the medication and the reason why.

▶ **If the parent tells you to stop giving the medication before the date written on the consent form:**

- ◆ Have the parent fill out the back on the consent form with the new discontinue date.
- ◆ Give the medication back to the parent.



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## Giving Medication Safely



You know the importance of matching the **Five Rights** written on the consent form with the information written on the medication label or package. Always have any supplies you may use *before* getting ready. You will match this information three times when:

### 1. Getting ready to give the medication:

- Look at the child's log to make sure the child didn't get the medication already.
- Get the correct child and make sure the child is ready to get the medication.
- Wash your hands and the child's hands.
- Once the child is ready, bring the child's consent form to where you store the medication and match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Once you take the medication from the storage area, you must never leave it in a place that is accessible to children.
- Check the instructions and package information to see if there are any special instructions for giving the medication, such as with food or on an empty stomach.
- If you did not check the expiration date on the consent form and medication at the beginning of the day, check it now.
- Follow the instructions to prepare the medication. This will be different depending on the route and the medication. Look at the package or insert, if needed.

### 2. Giving the medication:

- Match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Give the medication by following the instructions written on the package, the consent form and any special instructions for the way you are giving the medication. (See Handouts 7.1 – 7.8.)

### 3. Writing down that you gave the medication:

- Immediately write down that you gave the medication in the child's log.
- Match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Return the medication to the storage area.
- Wash your hands and the child's hands again.
- Help the child return to the group.



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# Hand Washing<sup>1</sup>



Caregivers and volunteers must thoroughly wash their hands with soap and running water:

- at the beginning of each day,
- before and after the administration of medications,
- when they are dirty,
- after toileting or assisting children with toileting,
- after changing a diaper,
- before and after food handling or eating,
- after handling pets or other animals,
- after contact with any bodily secretion or fluid, and
- after coming in from outdoors.

Caregivers and volunteers must ensure that children thoroughly wash their hands or assist children with thoroughly washing their hands with soap and running water:

- when they are dirty,
- after toileting,
- before and after food handling or eating,
- after handling pets or other animals,
- after contact with any bodily secretion or fluid, and
- after coming in from outdoors.

All staff, volunteers, and children will wash their hands using the following steps:

- 1) Moisten hands with water and apply liquid soap.
- 2) Rub hands with soap and water for at least 30 seconds – remember to include between fingers, under and around fingernails, backs of hands, and scrub any jewelry.
- 3) Rinse hands well under running water with fingers down so water flows from wrist to finger tips.
- 4) Leave the water running.
- 5) Dry hands with a disposable paper towel or approved drying device.
- 6) Use a towel to turn off the faucet and, if inside a toilet room with a closed door, use the towel to open the door.
- 7) Discard the towel in an appropriate receptacle.
- 8) Apply hand lotion, if needed.

When soap and running water is not available and hands are visibly soiled, individual wipes may be used in combination with hand sanitizer. The use of hand sanitizers on children under the age of two (2) years is prohibited.

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<sup>1</sup> Adapted from the Office of Children and Family Services Health Care Plan, Appendix B.



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## Using Gloves



Gloves are worn for your protection. When you give some types of medication to children, you may come in contact with the child's body fluids. Since body fluids may be infected with transmittable illnesses, it is important to protect yourself by wearing gloves. Wear gloves whenever there is a possibility of contact with:

- all body fluids such as:
  - ◇ nasal secretions
  - ◇ saliva
  - ◇ tears
  - ◇ vomit
  - ◇ urine
  - ◇ stool
- blood
- non-intact (broken) skin
- mucous membranes, like gums and nasal passages

### *How to Use Gloves<sup>1</sup>*

1. Wash hands.
2. Put on a clean pair of gloves. Do not reuse medical gloves.
3. Administer the treatment or medication or clean the medication prep site.
4. Remove the first glove by pulling at the palm and stripping the glove off. The entire outside surface of the gloves is considered dirty. Have dirty surfaces touch dirty surfaces only.
5. Ball up the first glove in the palm of your other gloved hand.
6. Use your ungloved hand to strip off the other glove without touching the outside of the glove with your ungloved hand. Insert a finger underneath the glove at the wrist and push the glove up and over the glove in your palm. The inside surface of your glove and your ungloved hand are considered clean. Be careful to touch clean surfaces to clean surfaces only. Do not touch the outside of the glove with your ungloved hand.
7. Drop the dirty gloves into a plastic-lined trash receptacle.
8. Wash hands.



**Glove use does not replace hand washing. You must always wash your hands after removing and disposing of medical gloves.**

<sup>1</sup> Adapted from the Office of Children and Family Services Health Care Plan, Appendix F.



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# Cleaning and Sanitizing<sup>1</sup>



***Equipment, toys and objects used or touched by children will be cleaned and sanitized as follows:***

1. Equipment that is frequently used or touched by children on a daily basis must be cleaned and disinfected when soiled and at least once weekly.
2. Carpets contaminated with blood or bodily fluids must be spot-cleaned.
3. Diapering surfaces must be disinfected after each child.
4. Countertops, tables and food preparation surfaces (including cutting boards) must be cleaned and disinfected before and after food preparation and eating.
5. Potty chairs must be emptied and disinfected after each use. They must not be washed out in a hand washing sink, unless that sink is washed and disinfected after such use.
6. Toilet facilities must be kept clean at all times and must be supplied with toilet paper, soap, and disposable towels accessible to the children.
7. Any surface that comes in contact with blood or bodily fluids must be disinfected immediately.
8. Thermometers and toys mouthed by children must be soaked in a disinfectant before use by another child.

## ***Sanitizing Solution***

Unscented chlorine bleach is the most commonly used sanitizing agent, because it is affordable and easy to get. The State Sanitary Code measures sanitizing solution in “parts per million,” but you can make the correct strength sanitizing solution without having to buy any special equipment. Follow these two easy steps: (1) read the label on the bleach container; and (2) use common household measurements.

### **Read the Label**

Sodium hypochlorite is the active ingredient in chlorine bleach. Different brands of bleach may have different amounts of this ingredient: *the measurements shown in this handout are for bleach that contains 6% to 8.25% sodium hypochlorite*. The only way to know how much sodium hypochlorite is in the bleach is by reading the label. Always read the bleach bottle to determine its concentration before buying it. *If the concentration is not listed, you should not buy that product.*

### **Use Common Household Measurements**

Using bleach that contains *6% to 8.25% sodium hypochlorite*, make two standard recommended bleach solutions for spraying nonporous or hard surfaces and a separate solution for soaking toys that have been mouthed by children. Always label each spray bottle with its respective mixture and purpose. Keep it out of children’s reach. The measurements for each type of sanitizing solution are specified on the next page.

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<sup>1</sup> Adapted from the Office of Children and Family Services Health Care Plan, Appendix E.

### **SPRAY BLEACH SOLUTION #1 for food contact surfaces**

Use the following procedures for cleaning and sanitizing nonporous hard surfaces, such as tables, countertops, and other food contact surfaces:

1. Wash the surface with soap and water.
2. Rinse until clear.
3. Spray the surface with a solution of  $\frac{1}{2}$  *teaspoon of bleach to 1 quart of water* until it glistens.
4. Let sit for 2 minutes.
5. Wipe with a paper towel or let air-dry.

### **SPRAY BLEACH SOLUTION #2 for diapering surfaces or surfaces that have been contaminated by blood or bodily fluids**

Use the following procedures for cleaning and sanitizing diapering surfaces or surfaces that have been contaminated by blood or bodily fluids:

1. Put on gloves.
2. Wash the surface with soap and water.
3. Rinse in running water until the water runs clear.
4. Spray the surface with a solution of *1 tablespoon of bleach to 1 quart of water* until it glistens.
5. Let sit for 2 minutes.
6. Wipe with a paper towel or let air-dry.
7. Dispose of contaminated cleaning supplies in a plastic bag and secure.
8. Remove gloves and dispose of them in a plastic-lined receptacle.
9. Wash hands thoroughly with soap under running water.

### **SOAKING BLEACH SOLUTION for sanitizing toys that have been mouthed**

Use the following procedure to clean and disinfect toys that have been mouthed by children:

1. Wash the toys in warm soapy water, using a scrub brush to clean crevices and hard-to-reach places.
2. Rinse in running water until water runs clear.
3. Place toys in soaking solution of *1 teaspoon of bleach to 1 gallon of water*.
4. Soak for 5 minutes.
5. Rinse with cool water.
6. Let toys air-dry.

**When sanitizing equipment, toys, and solid surfaces, the program will use (check all that apply):**

- EPA-registered product
- bleach solution made fresh each day
  - ◇ *Spray solution #1:  $\frac{1}{2}$  teaspoon of bleach to 1 quart of water*
  - ◇ *Spray solution #2: 1 tablespoon of bleach to 1 quart of water*
  - ◇ *Soaking solution: 1 teaspoon of bleach to 1 gallon of water*

## Applying Medication Topically



Topical medication comes in many forms such as:

- gels
- creams
- ointments
- aerosols

In addition to any medication-specific instructions, follow these principles when applying medication topically:

- You should wear gloves if:
  - ◇ the skin on your hands is cut, scabbed or broken;
  - ◇ the child's skin where the medication is to be applied is cut, scabbed or broken;
  - ◇ the medication to be applied should not touch **your** skin; or
  - ◇ you feel more comfortable wearing gloves to apply the medication.
- For non-aerosol topical medication, squeeze the appropriate amount of medication into your gloved hand.
- If you need to apply more medication, change gloves and squeeze the medication into the clean glove.
- Apply or spray the medication evenly on the skin.
- When spraying any topical medication, shield the child's face or have the child turn away from the spray and close his/her eyes.



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## Applying Medicated Patches



Medicated patches are applied to the child's skin so the medication can be slowly absorbed by the child's body. Medicated patches are left on the child for different lengths of time, so be sure you know if you or the parent is responsible for removing it.

You should also know what to do if the child removes the patch or if it falls off before the scheduled time to remove it.

In addition to any medication-specific instructions, follow these principles when applying a medicated patch:

- Before you put the patch on the child, write the date and time on it with a waterproof pen or marker.
- Put on gloves. You should wear gloves if:
  - ◇ the skin on your hands is cut, scabbed or broken;
  - ◇ the child's skin where the medication is to be applied is cut, scabbed or broken;
  - ◇ the medication to be applied should not touch *your* skin; or
  - ◇ you feel more comfortable wearing gloves to apply the medication.
- Choose the area where you will put the new patch. The area you choose should be free from any cuts or broken skin. Alternate sites unless otherwise instructed.
- Clean the area where you are putting the patch with soap and water.
- Be sure the area is dry before you put the patch on.

Follow these principles when removing a medicated patch:

- Put on gloves and remove the patch.
- Clean any medication left on the child's skin using soap and water, unless otherwise instructed.
- Throw away the used patch, rolled up inside the dirty gloves.



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## Giving Medication by Mouth



Oral medication comes in many forms, such as tablets, liquids and melts, or it may be rubbed on the gums in the mouth.

In addition to any medication-specific instructions, follow these principles to give medication by mouth:

- When removing medication from a container, avoid touching it with your bare hands. Pour the number of tablets or capsules you need into the container cap and then into a small cup. If you pour too much, return the excess to the bottle without touching it.
- You make the decision on wearing gloves. Whether or not you must wear gloves depends on how the medication is prepared and if you may be exposed to any body fluids while giving it.
- Never crush or split medication or open capsules unless instructed to do so by the pharmacist or child's health care provider.
- If you need to put the medication in food, use only a small amount of food to be sure the child can finish it all.
- If the child needs to swallow the medication, watch the child take the medication and look in the child's mouth and under the tongue to make sure the child swallowed it.



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## Measuring Liquid Medication



The child's full name must be written on the measuring tool. The tool must also have the exact measurement that matches the amount of medication the instructions tell you to give. Do not convert doses from one form of measurement to another.

In addition to any medication-specific instructions, follow these principles when measuring any liquid medication:

- If you want to mark the correct dose on the tool, be sure to mark next to the measurement line, not over it.
- To avoid getting medication on the label, pour the medication out of the bottle away from the label.
- Use the lowest point of the curvature, not the edges, to make sure you have the right amount of medication.
- If you pour too much into the tool, pour the excess into a clean disposable cup.
- If you need more medication, instead of using the medication bottle, use the extra in the clean disposable cup to get the right dose.
- Unless otherwise instructed, you can return this leftover medication to the original container.

### ***If you are using a MEDICINE CUP:***



- Put the cup on a flat surface after you have poured the medication and check it at eye level.
- Pour a small amount of water into the cup after you give the medication and swish it around to get any medication that may have stuck to the sides and have the child drink the water.

### ***If you are using a DOSING SPOON:***

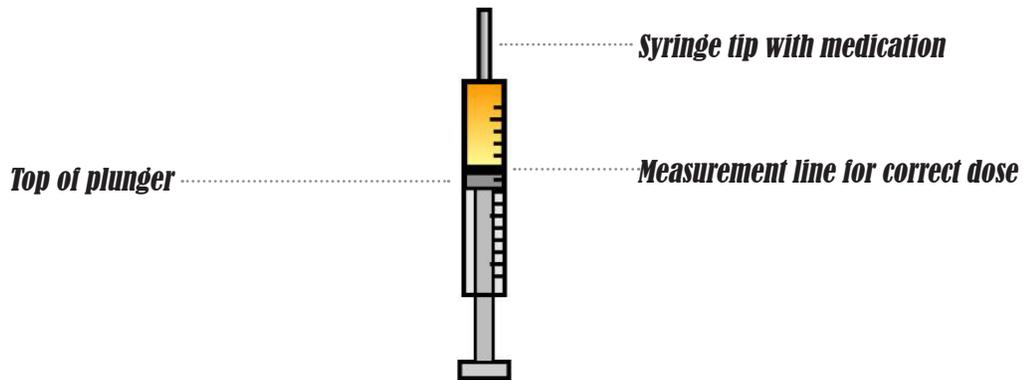


- Check the medication dose at eye level.
- Wipe off any excess medication that may be on the outside or in the "lip" of the dosing spoon to make sure you are giving the correct dose.
- Pour a small amount of water into the spoon after you give the medication and swish it around to get any medication that may have stuck to the sides and have the child drink the water.

**If you are using an ORAL MEDICATION SYRINGE:**



- If there is a cap on the syringe, take it off and throw it away, as this can be a choking hazard.
- Make sure the plunger is pushed all the way down into the syringe and draw up the medication.
  - *If the bottle has an adapter*, put the syringe in the adapter and pull the syringe plunger until you get the correct dose.
  - Follow any other directions provided.
- OR—
- *If the bottle does **not** have an adapter*, pour a *small* amount of medication into a disposable cup.
- Place the tip of the syringe into the liquid in the disposable cup.
- Pull the plunger to draw up the right dose of medication.
- Bring the top of the plunger to the line on the syringe that is the right dose.
- The tip of the syringe must be filled with medicine in order for the dose to be correct.



- Remove all air bubbles. To do this:
  - Turn the syringe so the tip is pointing toward the ceiling.
  - Tap the syringe to move the air bubbles to the top of the syringe.
  - Slowly push the plunger until the air bubbles are gone.
  - If the syringe tip is offset, you may need to angle the syringe to push all of the air bubbles out.
- Recheck the syringe at eye level to make sure the dose is correct.
- Wipe off any medication on the outside of the syringe to be sure you are giving the correct dose.
- Carefully place the syringe in the child's mouth between the rear gum and cheek. Do not squirt more medication than the child can swallow at one time.



Handout 7.4

### ***Cleaning Medication Tools***

Always keep medication tools clean. This will help avoid giving a wrong dose and prevent possible infections. You can wash medicine cups, dosing spoons, oral syringes and pill crushers with dishwashing soap and water. Never put an oral medication syringe in the dishwasher.



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## Giving Medication Inhaled by Mouth



Medication can be inhaled by mouth using an inhaler, inhaler with a spacer, a nebulizer or other device.

In addition to any medication-specific instructions, follow these principles to give medication inhaled by mouth:

### ***Metered-Dose Inhalers (MDIs)***

A metered-dose inhaler is a device used to deliver a precise dose of medication from a multi-dose container, into the lungs.

### ***When using a metered-dose inhaler (MDI)***

- Put on gloves. You should wear gloves if:
  - ◇ the skin on your hands is cut, scabbed or broken;
  - ◇ your hands might come in contact with the child's mucous;
  - ◇ the medication to be given should not touch **your** skin; or
  - ◇ you feel more comfortable wearing gloves to apply the medication.
- Remove the cap and check the mouthpiece for foreign objects before using.
- Read package instructions. Most inhalers need to be shaken before administration.
- Have the child breathe according to the package instructions.
- If the child needs two or more puffs, follow the instructions for how long to wait before giving another puff.
- Always watch the child use the inhaler.
- Check the counter on the MDI to see how many doses are remaining. Since some inhalers will continue to spray after the medication is gone from the container, discuss with the parent if you need to count the number of puffs you give.

A spacer may be used to help the child get the full dose of medication by holding the medication in the chamber long enough so the child can breathe the medication in with multiple breaths.

To help prevent the spread of germs or giving a wrong dose due to buildup of medication, keep the inhaler and spacer clean. Follow the instructions for cleaning. Never put the medication canister in water.

### ***Nebulizers***

A nebulizer is an air compressor device that finely disperses a liquid drug in a mist that is inhaled through the mouth and/or nose.

### ***When using a nebulizer***

- Be sure you know how to assemble the nebulizer parts and use the machine.
- Check to make sure you have all of the necessary nebulizer parts.
- Turn on the machine to make sure it is working.
- Attach the tubing and nebulizer parts to the compressor per the manufacturer's instructions.
- Medication administered by nebulizer will come in a single-dose vial. Be sure to read the health care provider instructions. Read and follow storage instructions, as most medication administered by nebulizer must be kept in a dark location.
- Put on gloves.
- Watch the child during the entire treatment to make sure (s)he gets all of the medication.

To help prevent the spread of germs or giving a wrong dose due to buildup of medication, keep the nebulizer and parts clean. Follow the manufacturer's instructions for cleaning.

### ***Sharing nebulizer machines***

Unless a nebulizer machine is labeled "for single patient use," your program can have a nebulizer machine that is shared by two or more children. Make sure the parent agrees if you are sharing a nebulizer.

Each child must have his or her own tubing, medication cup and mouthpiece or facemask. These should be kept in a separate labeled bag. In addition, the manufacturer's instructions regarding use and care of the machine must be followed.

## Giving Medication Inhaled Through the Nose



Medication can be inhaled into the body through the nose using a spray or drops.

In addition to any medication-specific instructions, follow these principles to give inhaled nasal medication:

- Put on gloves. You should wear gloves if:
  - ◇ the skin on your hands is cut, scabbed or broken;
  - ◇ your hands might come in contact with the child's mucous;
  - ◇ the medication to be given should not touch **your** skin; or
  - ◇ you feel more comfortable wearing gloves to apply the medication.
- It's a good idea to have the child blow his/her nose or wipe away any visible mucous.
- Let the child know (s)he may taste the drops or spray.
- Position the child's head, tilted slightly back.
- When using a dropper-tipped bottle, gently push up on the tip of the child's nose so you can see the nostrils and put the tip just a little into the nose.
- When using a nasal spray, plug the other nostril as you give the dose so the child can breathe the medication in correctly.
- Wipe the dropper tip or sprayer tip off after giving the dose.



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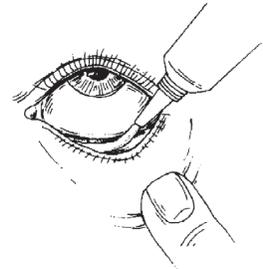
## Giving Medication in the Eye



Medication can be given in the eye using drops or ointment.

In addition to any medication-specific instructions, follow these principles when putting medication in the eye:

- When giving medication to only one eye, be careful to put the medication into the correct eye. Remember that if the child is facing you, the child's eye on your left side is actually the child's right eye, so be sure you know which eye is the correct eye.
- Put on gloves. You should wear gloves if:
  - ◇ the skin on your hands is cut, scabbed or broken;
  - ◇ your hands might come in contact with the child's mucous;
  - ◇ the medication to be given should not touch **your** skin; or
  - ◇ you feel more comfortable wearing gloves to apply the medication.
- Clean the child's eye with a clean tissue, wiping from the inner corner to the outside edge.
- Have the child sit or lie down. Older children can usually sit for eye drop medication. You may find it easier to have a young child lie down.
- With one hand, make a pocket in the child's lower eyelid.
- Using your other hand, put the medication in the pocket of the child's lower eyelid. **Do not drop directly into the eye.**
- Very often children blink when getting eye drops. If the drop completely misses his eye, you can give the dose again. If any amount gets in the eye, don't give another dose.
- If giving an ointment, start from the inner part of the eye that is closest to the child's nose and go outward toward the child's ear.





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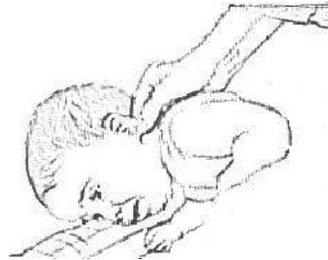
## Giving Medication in the Ear



In addition to any medication-specific instructions, follow these principles to put medication in the ear:

- If the outer part of the child's ear has some crusting or earwax, you should put on gloves and gently remove this with a single-use towel. Do not put anything into the child's ear canal.
- Many ear drops are kept in the refrigerator, so be sure to warm any cold medicine by rolling the bottle between the palms of your hands.
- When you are ready to give the drop, straighten the child's ear canal.

- ***For children under 3:***  
Hold earlobe and gently pull down and back.



- ***For children over 3:***  
Hold upper part of ear and gently pull up and back.



- Place the drops so they will roll into the ear along the side of the ear canal. Be careful to not drop directly into the ear. This can be painful and cause the child to experience nausea or dizziness.



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## Skills Practice Scenario: Giving Liquid by Mouth



### **Scenario**

Michelle Lewis is a three-year-old child who attends your program. She has an ear infection and gets an antibiotic called amoxicillin, given every day at 2PM for two weeks. Her mother gave you a medicine cup to use when giving the medication.

Today is October 4th at 1:50PM.

Using the attached paperwork, give Michelle her medication.



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OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name: Michelle Lewis		2. Date of Birth: 9/19/XX		3. Child's Known Allergies: None	
4. Name of Medication ( <i>including strength</i> ): Amoxicillin suspension 250mg/5ml			5. Amount/Dosage to be Given: 1 teaspoon		6. Route of Administration: Oral
7A. Frequency to be administered: <u>2PM</u>					
<b>OR</b>					
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): _____					
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )					
<b>AND/OR</b>					
8B. Additional side effects: _____					
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other ( <i>describe</i> ): _____					
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )					
<b>AND/OR</b>					
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____					
11. Reason for medication ( <i>unless confidential by law</i> ): <u>Ear infection</u>					
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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#33 and #35) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete (#34 -#35) on the back of this form.					
14. Date Health Care Provider Authorized: 10/1/XX			15. Date to be Discontinued or Length of Time in Days to be Given: 14 days		
16. Licensed Authorized Prescriber's Name (please print): Nancy Wallace, MD			17. Licensed Authorized Prescriber's Telephone Number: (914) 564-9832		
18. Licensed Authorized Prescriber's Signature: <b>X</b> <i>Nancy Wallace, MD</i>					

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

**PARENT 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 licensed authorized prescriber write 12pm?)  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm): \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child's name):  
Michelle Lewis

21. Parent's Name (please print):  
Jennifer LaBarge

22. Date Authorized:  
10/1/XX

23. Parent's Signature:  
 *Jennifer LaBarge*

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

24. Program Name:  
ABC Child Care

25. Facility ID Number:  
01376 DCC

26. Program Telephone Number:  
(212) 555-8363

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 day care program.

28. Staff's Name (please print):  
Anne Barber

29. Date Received from Parent:  
10/2/XX

30. Staff Signature:  
 *Anne Barber*

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

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

34. 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 you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

OCFS-LDSS-7004 (5/2014) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**LOG OF MEDICATION ADMINISTRATION**

- Caregivers may use this form or an approved equivalent to document medications administered in the day care program.
- Documentation must be kept with the child's written medication consent form.
- Any doses of the medication listed below not given must be documented.

**CHILD NAME:** Michelle Lewis

**MEDICATION:(including dose)**

Amoxicillin suspension (250mg/5ml)  
1 tsp

COMPLETE FOR ALL DOSES GIVEN				COMPLETE WHEN SIDE EFFECTS ARE NOTED		COMPLETE FOR 'AS NEEDED' MEDICATION ONLY	
Date Given (M/D/Y)	Dose	Time (AM or PM)	Administered by (full signature)	Any Noted Side Effects	Were parents notified of side effects?	For "as needed" medication – write the symptoms the child exhibited that necessitated the need for the medication	Were parents notified "as needed" medicine was given
10/2/XX	1 tsp	2:00 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Anne Barber		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
10/3/XX	1 tsp	2:05 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Anne Barber		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
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**DRUG NAME:** AMOXICILLIN SUS 250/5ML

**GENERIC NAME:** AMOXICILLIN (a-mox-i-SILL-in)

**HOW TO USE THIS MEDICINE:** Follow the directions for using this medicine provided by your doctor. SHAKE WELL before taking a dose. Use a measuring device marked for medicine dosing. Ask your pharmacist for help if you are unsure of how to measure this dose. You may mix this medicine with milk or formula before taking it. If you mix this medicine with milk or formula, use it immediately after mixing. THIS MEDICINE MAY BE TAKEN on an empty stomach or with food. Refrigeration may improve the taste of this medicine, but may not be required. Depending on the brand, when stored at room temperature, this medicine may expire earlier than if it was refrigerated. Check the bottle or ask your pharmacist to see if (and for how long) you can store this medicine at room temperature. TO CLEAR UP YOUR INFECTION COMPLETELY, continue taking this medicine for the full course of treatment even if you feel better in a few days. Do not miss any dose. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

**CAUTIONS:** DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a penicillin antibiotic (such as amoxicillin, ampicillin) or a cephalosporin antibiotic (such as Ceclor, Keflex, Cefin, Duricef). A severe reaction includes a severe rash, hives, breathing difficulties, or dizziness. If you have a question about whether you are allergic to this medicine, contact your doctor or pharmacist. IF MODERATE TO SEVERE DIARRHEA OCCURS during or after treatment with this medicine, check with your doctor or pharmacist. Do not treat it with non-prescription (over-the-counter) medicines. IF YOU EXPERIENCE difficulty breathing or tightness of chest; swelling of eyelids, face, or lips; or develop a rash or hives, tell your doctor immediately. Do not take any more of this medicine unless your doctor tells you to do so. This medicine may cause temporary staining of the teeth. Proper brushing will usually remove this staining and may prevent it from occurring. IF YOU HAVE DIABETES, this medicine may cause false test results with some urine glucose tests. Check with your doctor before you adjust the dose of your diabetes medicine or change your diet.

**POSSIBLE SIDE EFFECTS:** SIDE EFFECTS, that may go away during treatment, include nausea, vomiting, mild diarrhea, or irritation of mouth or throat. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience vaginal irritation or discharge. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

**BEFORE USING THIS MEDICINE:** Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking tetracycline antibiotics. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking anticoagulants or methotrexate. Inform your doctor of any other medical conditions or allergies. Contact your doctor or pharmacist if you have any questions about taking this medicine.

**OVERDOSE:** If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include nausea, vomiting, and diarrhea.

**ADDITIONAL INFORMATION:** If your symptoms do not improve within a few days or if they become worse, check with your doctor. DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children.

The information in this monograph is not intended to cover all possible uses, directions, precautions, drug interactions, or adverse effects. This information is generalized and is not intended as specific information. Check with your doctor, pharmacist, or nurse.



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## Evaluation Chart for Skills Demonstration



Remember, you cannot give verbal or nonverbal cues to the participant while (s)he is performing the skills demonstration. As the participant completes each step successfully, mark a  $\checkmark$  in the box. If the participant does not complete the step, leave the box blank. If the participant makes an error while performing a step, write down your observations.

Name of person completing demonstration: \_\_\_\_\_

Attempt:     1<sup>st</sup>     2<sup>nd</sup>

Name of person completing evaluation: \_\_\_\_\_

<b>Getting Ready to Give the Medication</b>	
The following steps must be completed <i>before</i> the participant gives the medication to the child. It does not matter in what order each step is done, as long as all steps are completed before the participant gives the medication.	
Task	Observed Skill?
Checks Michelle's Log of Medication Administration to be sure that the medication has not already been given.	
Gets Michelle and makes sure she is ready to take the medication.	
States that (s)he washed his/her hands and Michelle's hands.	
Brings consent form to medication storage area and gets correct medication by matching the <b>Five Rights</b> . When matching the <b>Five Rights</b> , the participant looks at both the consent form and medication package or label and states each right (i.e., the right medication is Amoxicillin and shows you where it is written on the consent form and the medication label) out loud while matching.  Put a check in each box below as the participant correctly states each of the <b>Five Rights</b> :  <input type="checkbox"/> Michelle Lewis <input type="checkbox"/> Amoxicillin suspension 250mg/5ml <input type="checkbox"/> 1 tsp <input type="checkbox"/> oral <input type="checkbox"/> 2PM	
Checks the medication or pharmacy label for an expiration date.	
<input checked="" type="checkbox"/> Put a check mark in this box if the participant successfully got the medication ready to give before giving the medication to the child.	

Giving the Medication	
Task	Observed Skill?
Shakes the medication well.	
Pours a small amount of medication into a clean cup, pouring the medication away from the label.	
Pours the medication in the medicine cup, puts the cup on a flat surface and checks the correct dose at eye level.	
Matches the <b>Five Rights</b> before giving the medication to Michelle by looking at both the consent form and medication package or label. Participant states each right out loud while matching.  Put a check in each box below as the participant correctly states each of the <b>Five Rights</b> :  <input type="checkbox"/> Michelle Lewis <input type="checkbox"/> Amoxicillin suspension 250mg/5ml <input type="checkbox"/> 1 tsp <input type="checkbox"/> oral <input type="checkbox"/> 2PM	
Gives the medication to Michelle.	
Pours a small amount of water into the cup to get any medication that may have stuck to the sides and gives that to Michelle.	
<input checked="" type="checkbox"/> Put a check mark in this box if the participant successfully gave the medication to the child.	

<b>Writing Down the Medication Administration</b>	
Task	Observed Skill?
<p>Immediately after giving the medication, the participant correctly and thoroughly writes down that (s)he gave the medication in Michelle’s <i>Log of Medication Administration</i>.</p> <p>Date: 10/04/XXXX            Dose: 1 teaspoon            Time: 1:50PM or can adjust to time taken to give—<i>must include AM/PM</i>            Signature: Must sign where indicated</p>	
<p>Matches the <b>Five Rights</b> by looking at both the consent form and medication package or label. Participant states each right aloud while matching.</p> <p><b>Put a check in each box below as the participant correctly states each of the Five Rights:</b></p> <p><input type="checkbox"/> Michelle Lewis   <input type="checkbox"/> Amoxicillin suspension 250mg/5ml   <input type="checkbox"/> 1 tsp   <input type="checkbox"/> oral   <input type="checkbox"/> 2PM</p>	
<p>The participant does not leave the medication unattended once removed from the safe storage area, and returns the medication to the safe storage area <b>immediately</b> after writing down the medication was given.</p>	
<p>Returns any medicine left in the cup back to the medicine bottle or disposes of leftover medication using an appropriate technique.</p>	
<p>Verbalizes that (s)he washed his/her hands and Michelle’s hands.</p>	
<p><input checked="" type="checkbox"/> Put a check mark in this box if the participant successfully got the medication ready to give before giving the medication to the child.</p>	

**PARTICIPANT SCORE:**

- Pass
- Fail (*Explain:* \_\_\_\_\_)
- Incomplete (*Explain:* \_\_\_\_\_)

**Rater’s Signature:** \_\_\_\_\_



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## Skills Practice Tools: Matching the *Five Rights*



Giving medication is a very serious part of your job. Knowing the **Five Rights** is not enough. To give medication, you must match the child's first and last names, medication, route, time, and dose written on the medication to the child's first and last names, medication, route, time, and dose written on the consent form to be sure you're giving the medication correctly. This is called matching the **Five Rights**.

Remember the following when matching the **Five Rights** to give medication:

### Right Child

- Match the child's first and last names written on the consent form with the names written on the pharmacy label or package to the child you are about to give the medication to.

### Right Medication

- Make sure the medication listed on the label of the container exactly matches the *Written Medication Consent Form*. Be careful, because the names of medication can sound alike and be spelled alike, but be very different medication.
- Some medication, such as inhalers, EpiPens® and creams, are inside a box with a pharmacy label on it. Always take the medication container out of the labeled box and match the medication name on the container with the label, including the strength.



### Right Dose

- Match the dose written on the consent form with the dose written on the pharmacy label or package with the dose you have prepared to give.

### Right Route

- Match the route written on the consent form with the route written on the pharmacy label or package with the way you are about to give the medication to the child.

### Right Time

- Match the time written on the *Written Medication Consent Form* with the time written on the pharmacy label and package with the current time. Remember that if the health care provider did not write the hour to give it (e.g., 12:00 PM), check the back of the consent form to see what time the parent wrote for you to give it.
- If the medication is given when the child needs it instead of at a specific hour, match the information written on the consent form and make sure it matches the child's symptoms. For example, if the instructions say to give Tylenol® when the child has a fever of 101°F or above, you would know it's the right time to give it if the child has a fever of 102°F.

## Skills Practice Tools: Giving Medication Safely



You know the importance of matching the **Five Rights** written on the consent form with the information written on the medication label or package. You will match this information three times when:

### 1. Getting ready to give the medication:

- Look at the child's log to make sure the child didn't get the medication already.
- Get the correct child and make sure the child is ready to get the medication.
- Wash your hands and the child's hands.
- Once the child is ready, bring the child's consent form to where you store the medication and match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Once you take the medication from the storage area, you must never leave it in a place that is accessible to children.
- Check the instructions and package information to see if there are any special instructions for giving the medication, such as with food or on an empty stomach.
- If you did not check the expiration date on the consent form and medication at the beginning of the day, check it now.
- Follow the instructions to prepare the medication. This will be different depending on the route and the medication. Look at the package or insert, if needed.

### 2. Giving the medication:

- Match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Give the medication by following the instructions written on the package, the consent form and any special instructions for the way you are giving the medication. (See Handouts 7.1 – 7.8.)

### 3. Writing down that you gave the medication:

- Immediately write down that you gave the medication in the child's log.
- Match the **Five Rights**.
  - child's full name     medication     dose     route     time
- Return the medication to the storage area.
- Wash your hands and the child's hands again.
- Help the child return to the group.

## Skills Practice Tools: Measuring Liquid Medication



The child's full name must be written on the measuring tool. The tool must also have the exact measurement that matches the amount of medication the instructions tell you to give. Do not convert doses from one form of measurement to another.

In addition to any medication-specific instructions, follow these principles when measuring any liquid medication:

- If you want to mark the correct dose on the tool, be sure to mark next to the measurement line, not over it.
- To avoid getting medication on the label, pour the medication out of the bottle away from the label.
- Use the lowest point of the curvature, not the edges, to make sure you have the right amount of medication.
- If you pour too much into the tool, pour the excess into a clean disposable cup.
- If you need more medication, instead of using the medication bottle, use the extra in the clean disposable cup to get the right dose.
- Unless otherwise instructed, you can return this leftover medication to the original container.

### ***If you are using a MEDICINE CUP:***



- Put the cup on a flat surface after you have poured the medication and check it at eye level.
- Pour a small amount of water into the cup after you give the medication and swish it around to get any medication that may have stuck to the sides and have the child drink the water.

### ***If you are using a DOSING SPOON:***

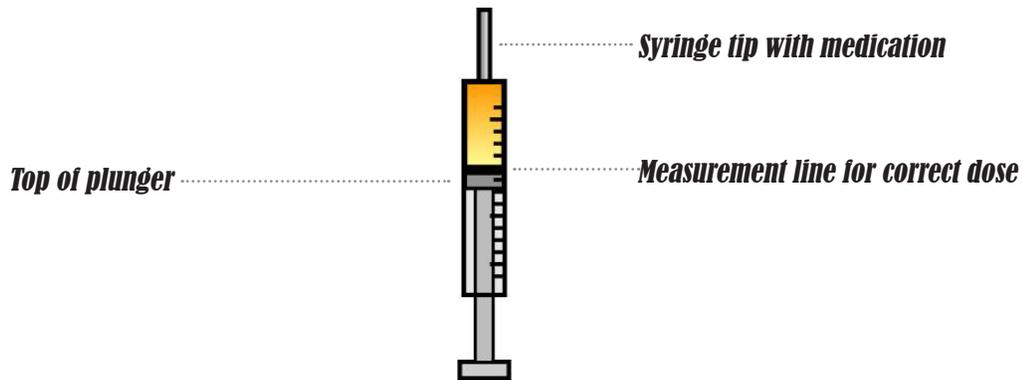


- Check the medication dose at eye level.
- Wipe off any excess medication that may be on the outside or in the "lip" of the dosing spoon to make sure you are giving the correct dose.
- Pour a small amount of water into the spoon after you give the medication and swish it around to get any medication that may have stuck to the sides and have the child drink the water.

**If you are using an ORAL MEDICATION SYRINGE:**



- If there is a cap on the syringe, take it off and throw it away, as this can be a choking hazard.
- Make sure the plunger is pushed all the way down into the syringe and draw up the medication.
  - *If the bottle has an adapter*, put the syringe in the adapter and pull the syringe plunger until you get the correct dose.
  - Follow any other directions provided.
- OR—
- *If the bottle does **not** have an adapter*, pour a *small* amount of medication into a disposable cup.
- Place the tip of the syringe into the liquid in the disposable cup.
- Pull the plunger to draw up the right dose of medication.
- Bring the top of the plunger to the line on the syringe that is the right dose.
- The tip of the syringe must be filled with medicine in order for the dose to be correct.



- Remove all air bubbles. To do this:
  - Turn the syringe so the tip is pointing toward the ceiling.
  - Tap the syringe to move the air bubbles to the top of the syringe.
  - Slowly push the plunger until the air bubbles are gone.
  - If the syringe tip is offset, you may need to angle the syringe to push all of the air bubbles out.
- Recheck the syringe at eye level to make sure the dose is correct.
- Wipe off any medication on the outside of the syringe to be sure you are giving the correct dose.
- Carefully place the syringe in the child's mouth between the rear gum and cheek. Do not squirt more medication than the child can swallow at one time.



Skills Practice 7.6

***Cleaning Medication Tools***

Always keep medication tools clean. This will help avoid giving a wrong dose and prevent possible infections. You can wash medicine cups, dosing spoons, oral syringes and pill crushers with dishwashing soap and water. Never put an oral medication syringe in the dishwasher.



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## Asthma Facts



- Asthma is a chronic disease of the lungs.
- Every child feels differently when having asthma symptoms, but most often will have repeated coughing, wheezing, breathlessness and chest tightness. These symptoms are from swelling (inflammation) of the airways. This makes the airways very sensitive and they usually react strongly to certain things (called triggers) in the environment.
- There is no cure for asthma, but with proper care it can be controlled.

**Triggers** are things that start an asthma episode. These can be viruses or other things in the environment that stimulate the child's immune system and cause airways to become inflamed. Except for colds, which trigger asthma episodes in most young children, triggers that start asthma episodes are different for each child. Things that trigger one child will not bother another. Also, triggers can change as a child grows older. You can help by knowing what triggers the child's asthma and avoiding them to reduce the child's risk of having an episode. Triggers may include:

Triggers	Prevention
Respiratory illness, such as a cold or the flu <i>A cold is the most common trigger of asthma in young children.</i>	Follow proper hand washing procedures; clean and sanitize toys and surfaces; flu vaccination
Tobacco smoke	Do not allow smoking in child care areas. Do not wear clothing that smells like cigarette smoke.
Cockroach and rodent droppings	Keep kitchen area clean; seal cracks in and around pipes; seal mouse holes.
Mold	Prevent water leakage; inspect bathrooms often for mold.
Dust, dust mites	Control dust; vacuum after children leave; mop with wet/damp cloths.
Pet dander	Keep pets out of child care areas at all times.
Perfume	Don't use perfumes or other strongly scented products.
Emotions, such as excitement or anxiety	Avoid emotional extremes.
Exercise	Give medication before exercise, if instructed to so by the child's health care provider.
Grass and tree pollens	Talk to parents about the best ways to limit triggers while their child is outside and pollen levels are high. Control pollen in child care areas; vacuum after children leave; mop with damp/wet cloths.
Cold air, humidity and changes in weather	Proper clothing; avoid temperature extremes.

**Early warning signs** are mild symptoms that happen *before* an asthma episode. Being able to spot early warning signs is helpful because you can take quick action. Early action may decrease the seriousness of the attack or even prevent an asthma episode from happening at all. Early warning signs are different for every child, so knowing each child's specific early warning signs is important. Some common early warning signs are:

- behavior changes, such as nervousness;
- coughing;
- stuffy or runny nose;
- headache;
- fatigue;
- watery eyes, itchy throat or chin.

***Signs and symptoms of an asthma episode:***

- acting agitated or scared
- breathing rapidly or differently
- wheezing
- can't stop coughing
- having trouble breathing when lying down
- sitting with shoulders hunched over
- unusually pale skin

***Management of an asthma episode:***

- Remove the child from asthma triggers.
- Calm the child to reduce anxiety.
- Give medication as instructed by the child's health care provider.  
(See the child's *Written Medication Consent Form*.)
- Call the child's parent or guardian.
- Follow the child's asthma care plan.
- Call 911, depending upon child's condition.

# Asthma Treatment



## **Medication Used to Treat Asthma**

Many children with asthma need to take medication at some point. Some children take a combination of medication to help manage their asthma. There are two types of asthma medication.

### **Controller Medication:**

These medications *control* asthma and can prevent asthma attacks. Some children may need to take medication on a regular basis to prevent an asthma episode. These medications are taken on a regular basis, usually daily. For children with persistent asthma, daily use of inhaled corticosteroids is the most effective treatment.

### **Quick Relief/Rescue Medication:**

Some children may only need medication when they are having an asthma episode or to prevent exercise-related asthma attacks. These medications work quickly to relieve asthma symptoms, but do not control airway inflammation or airway sensitivity.

## **Ways to Give Asthma Medication**

Asthma medications most commonly come in an inhaled form. How the child takes the medication depends on the type of medication and the age of the child.

### **Nebulizer Machine:**

A nebulizer machine converts liquid medicine into a mist that can be breathed into the lungs. The child breathes normally when using a nebulizer.

### **Metered-Dose Inhaler:**

A metered dose inhaler (MDI) is used to get the medication directly to the child's lungs.

### **Metered-Dose Inhaler with a Spacer Device:**

A spacer can be attached to a metered dose inhaler (MDI). When the MDI is pushed, the medication goes into the tube of the spacer. The child then easily breathes in the medication from the spacer tube over several breaths.

### **Dry Powder Inhaler:**

A dry powder inhaler is used to deliver dry powder medication directly to the lungs. Dry powder inhalers work differently than metered-dose inhalers, since the inhaler is activated when the child takes a breath.

### **Oral Medication:**

Oral medication may be prescribed for children either alone or in combination with inhaled medication.

## **Peak Flow Meter**

School-age children with persistent asthma can keep track of how well their asthma is controlled by using a peak flow meter. A peak flow meter is a portable handheld device used to measure how hard and fast the child can push air out of his lungs. Peak flow meter measurements can provide important information to help manage the child's asthma.



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## Example of a Care Plan for a Child with Asthma



**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

This plan is to help you know the child's triggers, early warning signs and symptoms of an asthma episode. It includes what you should do if the child has an asthma episode while in care.

If the child takes medication, follow the instructions on the child's *Written Medication Consent Form*.

**Known triggers** for this child's asthma (*circle all that apply*):

- |              |                 |
|--------------|-----------------|
| colds        | excitement      |
| mold         | weather changes |
| exercise     | animals         |
| tree pollens | smoke           |
| dust         | foods: _____    |
| strong odors | _____           |
| grass        | other: _____    |
| flowers      | _____           |

**Activities** when this child has needed special attention in the past (*circle all that apply*):

- |                                |                                |
|--------------------------------|--------------------------------|
| <i>Outdoors</i>                | <i>Indoors</i>                 |
| outdoors on cold or windy days | kerosene/wood stove            |
| jumping in leaves              | heated rooms                   |
| animals                        | painting or renovations        |
| running hard                   | art projects with chalk, glues |
| gardening                      | pet care                       |
| playing in freshly cut grass   | sitting on carpets             |
| recent lawn treatment          | other: _____                   |
| other: _____                   | _____                          |
| _____                          |                                |

**Early Warning Signs** for this child's asthma (*circle all that apply*):

- |                                       |                                     |
|---------------------------------------|-------------------------------------|
| behavior changes, such as nervousness | headache                            |
| rapid breathing                       | fatigue                             |
| wheezing, coughing                    | changes in peak flow meter readings |
| stuffy or runny nose                  | watery eyes, itchy throat or chin   |
| other: _____                          | _____                               |
| _____                                 | _____                               |

**Typical signs and symptoms** of this child’s asthma episodes (*circle all that apply*):

- |                           |   |
|---------------------------|---|
| fatigue                   | agitation                                     |
| red, pale or swollen face | flaring nostrils                              |
| grunting                  | mouth open (panting)                          |
| breathing faster          | persistent coughing                           |
| wheezing                  | complaints of chest pain/tightness            |
| restlessness              | gray or blue lips or fingernails              |
| dark circles under eyes   | difficulty playing, eating, drinking, talking |
| sucking in chest/neck     | Other: _____                                  |

**Peak Flow Meter**

Does this child use a **peak flow meter** to monitor the need for medication in care?  Yes  No

- Personal best reading ..... \_\_\_\_\_
- Reading to give extra dose of medicine..... \_\_\_\_\_  
(See the child’s *Written Medication Consent Form* for instructions.)
- Reading to get medical help..... \_\_\_\_\_

How often has this child needed urgent care from a doctor for an episode of asthma:

- in the past 3 months? \_\_\_\_\_
- in the past 12 months? \_\_\_\_\_

**Staff**

Identify the staff who will provide care to this child:

Name	Credentials or Professional License Information*

Describe any additional training, procedures or competencies the staff listed will need to care for this child. Also describe how this additional training and competency will be achieved, including who will provide this training. This includes training for using a peak flow meter, if the child uses one to help manage asthma.


**Plan of Action if child is having an asthma episode:**

1. Remove child from any known triggers.
2. Follow any health care provider instructions for administration of asthma medication.
3. Notify parents immediately if medication is administered.
4. Get emergency medical help if:
  - the child does not improve 15 minutes after treatment and family cannot be reached;  
**OR**
  - after receiving a treatment, the child:
    - ◇ is grunting or working hard to breathe;
    - ◇ won't play;
    - ◇ is breathing fast at rest (>50/min)
    - ◇ has gray or blue lips or fingernails;
    - ◇ has trouble walking or talking;
    - ◇ cries more softly and briefly;
    - ◇ has nostrils open wider than usual;
    - ◇ is hunched over to breathe;
    - ◇ has sucking in of skin (chest or neck) with breathing;
    - ◇ is extremely agitated or sleepy;
    - ◇ passes out or stops breathing.

**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. \*I understand that it is my responsibility to see that the staff identified to provide all treatments and administer medication to the child listed in this health care plan have a valid MAT certificate, CPR and first aid certifications, if applicable, or have a license that exempts them from training; and have received any additional training needed, and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name:	Facility ID number:	Facility Telephone Number:
Authorized child care provider's name (please print):		Date:
Authorized child care provider's signature:		

**Signature of Parent or Guardian**

	Date:
--	-------



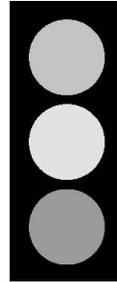
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# New York State Department of Health Asthma Action Plan



## Asthma Action Plan

Name	Date
Doctor	Medical Record #
Doctor's Office Phone #: Day	Night/Weekend
Emergency Contact	
Doctor's Signature	



The Colors of a traffic light will help you use your asthma medicines.

**Green** means **Go Zone!**  
Use preventive medicine.

**Yellow** Means **Caution Zone!**  
Add quick-relief medicine.

**Red** means **Danger Zone!**  
Get help from a doctor.

Personal Best Peak Flow \_\_\_\_\_

### GO

You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from \_\_\_\_\_  
to \_\_\_\_\_

### CAUTION

You have **any** of these:

- First signs of a cold
- Exposure to known trigger
- Cough
  - Mild wheeze
- Tight chest
  - Coughing at night

Peak flow from \_\_\_\_\_  
to \_\_\_\_\_

### DANGER

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow  
reading below  
\_\_\_\_\_

### Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

For asthma with exercise, take:

--	--	--

### Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR PRIMARY CARE PROVIDER.

### Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

**GET HELP FROM A DOCTOR NOW!** Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. **DO NOT WAIT.**

Make an appointment with your primary care provider within two days of an ER visit or hospitalization.



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## Preventing Unintentional Medication Poisoning



### *Tips for Keeping Children Safe:*

- Store all medication safely.
- Medication needs to be kept in an area out of children's reach and sight.
- Keep all medication in its original labeled container.
- Use childproof containers whenever possible.
- Never leave medication unattended.
- Always return medication to the storage area immediately after use.
- Never call medicine "candy."
- Keep important phone numbers, such as the Poison Control Hotline, on or near your telephone.
- Always follow the ***Five Rights*** when giving medication to children.

**If you suspect a child has accidentally taken medication or other poison, call the Poison Control number *immediately*.**

**Do not wait for the child to look or feel sick.**

***The Poison Control Center number is:***

***1-800-222-1222***



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## Anaphylaxis

Anaphylaxis is a severe allergic reaction that affects the whole body. The child will get worse quickly and the symptoms could become life-threatening. Here are some common things (allergens) that can cause a severe allergic reaction in children:

 <p>Nuts, including (but not limited to) peanuts and tree nuts (pecans, walnuts, cashews, etc.)</p>	 <p>Insect or bee venom from bites or stings</p>
 <p>Medications</p>	 <p>Seafood, including fish and shellfish</p>
 <p>Eggs</p>	 <p>Milk</p>
 <p>Wheat</p>	 <p>Berries</p>
 <p>Soy</p>	 <p>Latex</p>



***What does anaphylaxis look like?***

Look for the following symptoms of anaphylaxis so you can act fast:



- Itching
- Swelling of the lips and/or tongue
- Tingling of the lips and/or tongue
- Metallic taste in the mouth



- Shortness of breath
- Coughing
- Wheezing
- Difficulty breathing



- Itching
- Redness
- Hives
- Swelling
- Pale, cool and damp skin



- Itching
- Hoarseness
- Tightness/closure
- Difficulty swallowing



- Chest pain
- Weak pulse
- Dizziness
- Passing out
- Rapid heartbeat



- Confusion
- Headache



- Vomiting
- Nausea
- Diarrhea
- Cramps

If a child in your care shows *any* symptoms of anaphylaxis,

***call 911 immediately!***

## Epinephrine Auto-Injector (EpiPen® or Auvi-Q™) Use and Storage

Epinephrine is the medication that, when given as an injection, can help relieve the symptoms of anaphylaxis and can save a child's life. If a child in your care has known allergies to bee stings or certain foods, and has a history of anaphylaxis, the child's health care provider will probably prescribe epinephrine to be kept on hand.

Epinephrine auto-injectors come in two main forms:

- **EpiPen®** (including EpiPen® Jr) is a disposable, prefilled automatic injection device that contains a single dose of epinephrine.
- **Auvi-Q™** is a compact epinephrine auto-injector that talks you through the injection process step by step.

### ***EpiPen® Use and Storage***

#### ***To correctly ADMINISTER an EpiPen®***

- Remove the auto-injector from the clear carrier tube: Flip open the yellow cap of the EpiPen® or the green cap of the EpiPen Jr® Auto-Injector carrier tube. Tip and slide the auto-injector out of the carrier tube.
- Grasp the auto-injector in your fist with the orange tip pointing downward.  
*Note: The needle comes out of the orange tip. NEVER put your thumb, fingers, or hand over the orange tip.*
- With your other hand, remove the blue safety release by pulling straight up without bending or twisting it.
- Place the orange tip against the middle of the outer thigh at a right angle (perpendicular) to the thigh. While holding the leg firmly in place, swing and firmly push the orange tip against the outer thigh until it “clicks”. Hold firmly against the thigh for approximately 3 seconds (count slowly: 1, 2, 3) to deliver the drug. The injection is now complete.
- Remove the auto-injector from the thigh. The orange tip will extend to cover the needle. Massage the injection area for 10 seconds. Get emergency medical help right away. The child may need further medical attention. Symptoms can reoccur, even hours later, so even if the child seems better, (s)he still needs emergency care.
- Send the used auto-injector with the child to the hospital, and be sure to include the child's health history card.

**These instructions reflect the May 2016 revisions by the US Food and Drug Administration (FDA) and will differ from the package insert instructions for EpiPen® epinephrine auto-injectors manufactured before or near that date.**

*(continued on next page)*



### Handout 9.3

- The used auto-injector with extended needle cover will not fit in the carrier tube.
- Most of the liquid medicine stays in the auto-injector and cannot be reused. The child has received the correct dose of the medicine if the orange needle tip is extended and the window is blocked.
- Do not attempt to take apart the EpiPen® or EpiPen® Jr Auto-Injector.

It is standard protocol to send the used auto-injector with the child on the ambulance.

**Remember, an epinephrine auto-injector is a prescription medication that is for a specific child.** If a child in your care is having symptoms of anaphylaxis and does *not* have an auto-injector, get emergency help by calling 911. You **MAY NOT** use one child's auto-injector for another child under any circumstances.

#### ***STORING an EpiPen® or EpiPen Jr.®***

- Store EpiPen® or EpiPen Jr.® at room temperature between 68° to 77° F (20° to 25° C).
- Protect from light.
- **Do not** expose to extreme cold or heat. For example, **do not** store in a vehicle's glove box and **do not** store in the refrigerator or freezer.
- Examine the contents in the clear window of the auto-injector periodically. The solution should be clear. If the solution is discolored (pinkish or brown color) or contains solid particles, replace the unit.
- Always keep the EpiPen® or EpiPen Jr.® auto-injector in the carrier tube to protect it from damage; however, the carrier tube is not waterproof.
- The blue safety release helps prevent accidental injection. Keep the blue safety release on until you need to use EpiPen® or EpiPen Jr.®.
- The EpiPen® or EpiPen Jr.® has an expiration date. Replace it before the expiration date.
- **Keep EpiPen®/EpiPen Jr.® and all medication out of the reach of children. Store the auto-injector so it is easily accessible and you can get to it quickly, such as in a first aid kit or your program's emergency or "going outside" bag.**



## **Auvi-Q™ Use and Storage**

### **To correctly ADMINISTER an Auvi-Q™**

- Remove Auvi-Q™ from the outer case.  
*Once you have removed Auvi-Q™ from the outer case, it will begin playing audible instructions to guide you through administering the medication.*
- Pull off the red safety guard.
- Place the black end of Auvi-Q™ against the middle of the outer thigh (through clothing, if needed), then press firmly, and hold in place for 5 seconds.  
***Only inject into the middle of the outer thigh. Do not inject into any other part of the body.***
- After using Auvi-Q™, get emergency medical help right away

It is standard protocol to send the used auto-injector with the child on the ambulance.

**Remember, an epinephrine auto-injector is a prescription medication that is for a specific child.** If a child in your care is having symptoms of anaphylaxis and does *not* have an auto-injector, get emergency help by calling 911. You **MAY NOT** use one child's auto-injector for another child under any circumstances.

### **STORING an AuviQ™**

- Epinephrine is light sensitive and should be stored in the outer case provided to protect it from light. Store at 20° to 25° C (68° to 77° F); excursions permitted to 15° to 30° C (59° to 86° F) [See USP Controlled Room Temperature]. Do not refrigerate. Before using, check to make sure the solution in the auto-injector is clear and colorless. Replace the auto-injector if the solution is discolored, cloudy, or contains particles.



## How a Child Might Describe a Reaction

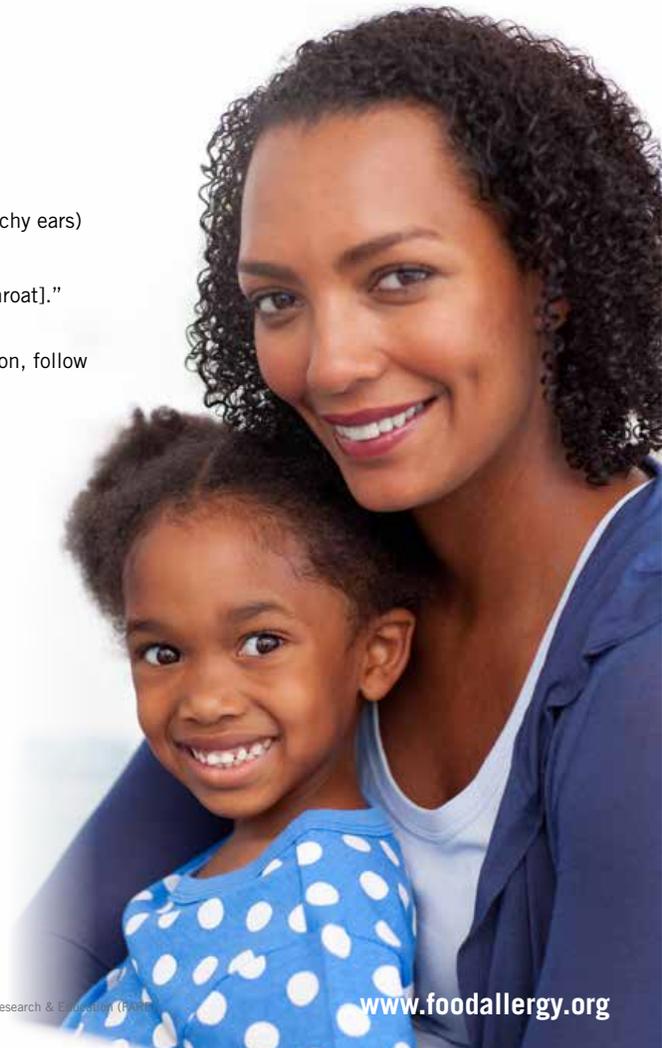
Children have unique ways of describing their experiences and perceptions, and allergic reactions are no exception. Precious time is lost when adults do not immediately recognize that a reaction is occurring or don't understand what a child is telling them.

Some children, especially very young ones, put their hands in their mouths or pull or scratch at their tongues in response to a reaction. Also, children's voices may change (e.g., become hoarse or squeaky), and they may slur their words. The following are examples of the words a child might use to describe a reaction:

- "This food is too spicy."
- "My tongue is hot [or burning]."
- "It feels like something's poking my tongue."
- "My tongue [or mouth] is tingling [or burning]."
- "My tongue [or mouth] itches."
- "It [my tongue] feels like there is hair on it."
- "My mouth feels funny."
- "There's a frog in my throat."
- "There's something stuck in my throat."
- "My tongue feels full [or heavy]."
- "My lips feel tight."
- "It feels like there are bugs in there." (to describe itchy ears)
- "It [my throat] feels thick."
- "It feels like a bump is on the back of my tongue [throat]."

If you suspect that your child is having an allergic reaction, follow your doctor's instructions and treat the reaction quickly.

Learn more about treatment at [www.foodallergy.org/treating-an-allergic-reaction](http://www.foodallergy.org/treating-an-allergic-reaction).



## Medication Errors



A medication error is a mistake that is made anytime during the process of administering medication. This includes failure to give a medication as instructed.

### **Medication errors include:**

- Forgetting to give medication
- Giving the wrong medication
- Giving medication at the wrong time  
*(This includes giving medicine more than 30 minutes before or more than 30 minutes after the scheduled time OR giving medication for symptoms that are not specified by the health care provider.)*
- Giving the wrong dose of medication
- Giving medication by the wrong route
- Giving medication to the wrong child
- Giving an expired medication
- Giving medication without parental permission
- Giving medication without valid health care provider instructions, including expired consents

### **Reporting a Medication Error**

1. As soon as you discover an error, immediately contact the child's parent. Encourage the parent to contact the child's health care provider to decide what to do.
2. Provide for the immediate needs of the child as directed by the child's parent and health care provider.
3. Complete the *OCFS Medication Error Report Form* or approved equivalent and submit it to your licenser or registrar.
4. You must notify your licenser or registrar within 24 hours of the error.

If an error occurs in your program, look for any circumstances or current medication administration policies that may have contributed to the error. Your health care consultant is a good resource for helping you to determine what went wrong. With this knowledge, you can make changes to prevent any future mistakes.



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OCFS-LDSS-7005 (5/2014) FRONT

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION ERROR REPORT FORM**

- You may use this form or an approved equivalent to report medication errors.
- All sections of this form must be completed.
- The child's parent must be notified immediately of all medication errors.
- The Office of Children and Family Services (OCFS) must be notified of all medication errors within 24 hours of the medication error. Verbal notification to Office must occur within 24 hours, followed by submitting this form by mail, fax or email.
- If more than one child is involved in the error, an error form must be completed for each child.

PROVIDER NAME:	LICENSE/REGISTRATION NUMBER:	PROGRAM TELEPHONE NUMBER:
CHILD NAME:		CHILD DATE OF BIRTH:
DATE OF MEDICATION ERROR:	TIME OF MEDICATION OF ERROR:	
<p>What type of medication error occurred:</p> <p><input type="checkbox"/> Incorrect child</p> <p><input type="checkbox"/> Incorrect medication</p> <p><input type="checkbox"/> Incorrect time (<i>gave more than 30 minutes before or 30 minutes after time authorized</i>)</p> <p><input type="checkbox"/> Incorrect dose</p> <p><input type="checkbox"/> Incorrect route</p> <p><input type="checkbox"/> Gave an expired medication</p> <p><input type="checkbox"/> Forgot to give medication</p> <p><input type="checkbox"/> Consent expired</p> <p><input type="checkbox"/> Other _____</p>		
<p>Complete this section for all errors using the information provided on the child's approved medication consent form. (<i>except for incorrect child</i>)</p>		
NAME OF MEDICATION AUTHORIZED:	AMOUNT/DOSAGE AUTHORIZED:	ROUTE OF ADMINISTRATION AUTHORIZED:
<p><b>Frequency to be administered or signs and symptoms that necessitate the need for the medication as authorized on the consent:</b></p>          		

OCFS-LDSS-7005 (5/2014) REVERSE

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION ERROR REPORT FORM**

**Describe the Incident (Include all individuals involved in the error):**

**ACTION TAKEN**

OCFS NOTIFIED VERBALLY: <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE NOTIFIED (mm/dd/yy): / /	TIME(AM/PM):	PERSON NOTIFIED:
FORM SUBMITTED TO OCFS: <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE NOTIFIED (mm/dd/yy): / /	PERSON NOTIFIED:	
PARENT NOTIFIED (Required Immediately): <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE NOTIFIED (mm/dd/yy): / /	TIME(AM/PM):	PERSON NOTIFIED:
OTHER PERSONS NOTIFIED (Ex. Health Care Provider, Health Care Consultant): <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE NOTIFIED (mm/dd/yy): / /	PERSON(S) NOTIFIED:	

**Describe Corrective Action:**

NAME OF PERSON COMPLETING THIS FORM: (Please Print):

DATE FORM COMPLETED:

SIGNATURE OF PERSON COMPLETING THIS FORM:

**X**

## Independent Medication Administration



The New York State OCFS Child Day Care Regulations allow school-age children to carry and use an asthma inhaler or epinephrine auto-injector under the following circumstances:

*“No child in care will be allowed to independently administer medications, except for those medications administered pursuant to section 41\*.11(h)(6) of this Part, without the assistance and direct supervision of caregivers that are authorized to administer medications pursuant to section 41\*.11 of this Part. Any program that elects to offer the administration of medication to children when children who attend the program independently administer medications or when children assist in the administration of their own medications must comply with all the provisions of section 41\*.11 of this Part.”*  
[41\*.11(f)(3)]

*“When a program is approved to administer an inhaler to a child with asthma or other diagnosed respiratory condition, or an epinephrine auto injector for anaphylaxis, a school-aged child may carry and use these devices during day care hours if the program secures written permission of such use of a duly authorized health care provider, parental consent and completes a special health care plan for the child.”* [41\*.11(h)(6)]

***Whether a program is approved to administer medication or approved to administer emergency medication only***, the program must maintain on file the following for each school-age child who will independently administer his asthma inhaler or epinephrine auto-injector:

- written permission from the child’s health care provider;
- parental consent; and
- a completed Individual Health Care Plan for a Child with Special Health Care Needs for the school-age child. The child’s individual health care plan will:
  - ◆ state that staff approved to administer medication must be available when the child is in the program;
  - ◆ explain how the child will carry the medication and make sure it is not accessible to other children in the program;
  - ◆ explain how the child will tell program staff of any doses he administers;
  - ◆ explain how staff will document each dose the child takes independently;
  - ◆ explain how staff will recognize and respond to possible side effects; and
  - ◆ list any additional training or competencies staff approved to give medication may need to care for the child and who will provide this training.

The child’s parental consent, health care provider consent, and completed Individual Health Care Plan for a Child with Special Health Care Needs must document permission for a school-age child to carry an inhaler or auto-injector.

**Form OCFS-LDSS-7006: Individual Health Care Plan for a Child with Special Health Care Needs is available and may be used.**



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## Children with Special Health Care Needs



A **child with special health care needs** is defined by OCFS regulations as a child who has a “chronic physical, developmental, behavioral or emotional condition that is expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.”

To care for a child with special health care needs, you must work with the child’s parent and health care provider to write an *Individual Health Care Plan for a Child with Special Health Care Needs* (see Handout 10.5). The plan must:

- Describe the special health care needs of the child.
- List the program staff who will provide care to this child. All staff who will administer medication or treatments to the child must be approved medication administrators.
- Describe any additional training or skills the staff identified will need to give the medication or treatment to the child, what the training will be and who will provide this training.
- Have an authorized program representative and the parent sign the child’s *Individual Health Care Plan for a Child with Special Health Care Needs*. Keep the plan on file.

Because administration techniques and the needs of children differ, any training staff receive to care for a child with special health care needs is child-specific and is not transferable from one child to another.



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## Giving Medication when Away from the Program



If any children will need medication while off the program site, you will need:

- An approved medication administrant on the field trip if any of the children on the trip need medication.
- The medication in the original pharmacy container.
- The medication packed separately from food and other supplies.
- If the medication requires refrigeration, a way to keep it at a temperature between 36-46°F.
- Any administration tools or special equipment needed to give the medication.
- The child's original *Written Medication Consent Form* and *Log of Medication Administration*.
- Waterless hand washing gels in case there is no running water to wash hands.
- Emergency numbers for the area where you will be visiting.

### ***For children not going off-site:***

If any children will need medication while others are off the program site, you need:

- an approved medication administrant available to administer the medication; and
- The *Written Medication Consent Form* and *Log of Medication Administration* available for any child left at the program.



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## First Aid Kit



Each child care program must have a first aid kit stocked with the items needed to treat a broad range of injuries and situations.

Your health care plan lists what you will keep in your first aid kit and where in your program it will be kept. Larger programs usually have many kits.

In some areas, the local poison control officials may suggest that you include specific items in your first aid kit because of the time required to get emergency medical treatment. Be sure to check with them when preparing your first aid kit and follow their directions.

### ***Potassium Iodide (KI)***

Child care programs located within a 10-mile radius of a nuclear power plant were sent a letter from OCFS providing instructions for giving potassium iodide in the event of radioactive emissions. All programs, even those not approved to give medication, can keep potassium iodide in their first aid kit or emergency bag. Programs must inform parents of the program's geographic location and the use of potassium iodide.

Potassium iodide does not require a physician's prescription and, although giving potassium iodide to children in the event of radiation exposure is recommended, it is not required. You must get parents' consent if they do not want potassium iodide given to their children.



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## Next Steps



### ***MAT Certificate***

Once you successfully complete the MAT course, you can download and print your certificate from the ECETP website ([www.ecetp.pdp.albany.edu/mytraining/](http://www.ecetp.pdp.albany.edu/mytraining/)). Be sure to keep a copy for your records.

Your MAT certificate:

- is good for three years;
- identifies the language(s) in which you completed the MAT course (remember, you can only accept permissions, instructions, package inserts or related materials in a language in which you can read and write); and
- only allows you to give medication in a child care setting.

### ***What's Next?***

Completing the MAT course is only one part of what you need to become an approved medication administrant in your program.

You must meet *all* of the following requirements **before** you can give medication:

- Have a valid MAT certificate
- Have and maintain a current first aid certificate that covers the ages of the children in your care
- Have and maintain a current CPR certification that covers the ages of the children in your care
- Be at least 18 years old
- Be listed in your program's approved health care plan as a medication administrant
- Have your program's health care consultant review and sign the plan approving you as a medication administrant
- Have the signed health care plan approved by your program's licensor or registrar
- Work in a program with a printed license or registration that states the program is approved to give medication (except for legally exempt and NYC Day Care Center staff)

### ***Updates to the Handouts***

There may be times when handouts are updated or new handouts are added. All of the MAT handouts are available on our website: [www.ecetp.pdp.albany.edu](http://www.ecetp.pdp.albany.edu). Each handout is dated so you can check to see if you have the most current version.

**Certificate Expiration**

Your MAT Certification is good for a period of three (3) years from the date that you successfully completed the MAT course. If you are an approved medication administrant in a program approved to give medication, you are eligible to take the MAT renewal test.

You can renew your MAT certificate for another three years by taking the renewal test online. You may do this two consecutive times. Upon the third consecutive online renewal, you will also have to complete three (3) Skills Competencies in order to renew your MAT certification.

You will need a username and password to log on to take the test. You should receive your username and password in a letter from the MAT Program three to six months before your certificate expires.

If you do not receive a letter and are eligible to renew your MAT certificate, it is *your responsibility* to contact the MAT program or your licensor/registrar. If you fail to renew your MAT certification *before* the expiration date, you will have to retake the MAT course in order to continue administering medication in your program.

**Additional Resources**

- Health Care Consultant: \_\_\_\_\_

Contact number: \_\_\_\_\_

*If you do not know the health care consultant for your program or how to contact him/her, speak with your Director and find out how you can contact this person.*

- OCFS Licensor or Registrar: \_\_\_\_\_

Contact number: \_\_\_\_\_

- Medication Administration Training Program and MAT Rebate Program:

**1-800-295-9616**  
**MAT@albany.edu**

- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## MAT Reaction Questionnaire



**Instructor:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Please use this form to evaluate the Medication Administration Training (MAT) course you have just completed. It is important for us to know whether the training met your needs. All responses are anonymous.

**Instructions:** Please use the scale below to indicate your level of agreement with each of the following statements.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. The training was of overall high quality.	⑤	④	③	②	①
2. The training objectives were very clear.	⑤	④	③	②	①
3. The training was harder than I expected.	⑤	④	③	②	①
4. The length of the training was appropriate.	⑤	④	③	②	①
5. The instructor was very knowledgeable about the content.	⑤	④	③	②	①
6. The instructor was well prepared and well organized.	⑤	④	③	②	①
7. The room facilities were conducive to learning.	⑤	④	③	②	①
8. The materials and handouts were very helpful.	⑤	④	③	②	①
9. The training content was explained in a way that was clear and understandable.	⑤	④	③	②	①
10. Based on the information I received in this course, I feel prepared to give medication in my child care program.	⑤	④	③	②	①
11. I am planning to give medication in my program.	⑤	④	③	②	①
12. Is there any information you wished had been discussed in the training that would help you in giving medication to children in your care?					

13. Do you have any suggestions on ways to shorten the training?

Over

Please complete items on back

Over



14. Why did you decide to take the MAT course?

- My employer sent me
- Licensor/registrar recommended
- A child in my care needs medication
- Parent requested
- Professional growth
- Other child care provider recommended
- Other: \_\_\_\_\_

15. How long have you been a child care provider working in a licensed or registered child care program?

- Less than 6 months
- 6 months to 1 year
- 1 to 3 years
- 4 to 5 years
- 5 to 10 years
- Over 10 years

16. What type of child care program do you work in?

- Family day care
- Group family day care
- Day care center
- School-age child care program
- Legally exempt child care receiving state subsidy

17. What region of New York State do you work in?

- Buffalo (*Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties*)
- Rochester (*Chemung, Livingston, Monroe, Ontario, Seneca, Schuylar, Steuben, Wayne and Yates counties*)
- Syracuse (*Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga and Tompkins counties*)
- Albany (*Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties*)
- Yonkers (*Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester counties*)
- New York City (*boroughs of The Bronx, Brooklyn, Manhattan, Queens and Staten Island*)
- Long Island (*Nassau and Suffolk counties*)

18. Please enter your age: \_\_\_\_\_

19. Highest level of education achieved:

- Less than high school diploma/GED
- High school diploma/GED
- Some college, no degree
- Child Development Associate (CDA) or other child care credential
- Associate's degree
- Bachelor's degree
- Master's degree or above

**Thank you!**