Capital Community College

Medication Policy

Trained staff members who are authorized may administer the following medications to a child after all criteria are met. All medications will be administered only after at least one dose has been given by the parent or guardian (not applicable for injectables). Medications will not be routinely given during nap times unless it is a medication for a life threatening situation.

**Medications**

Inhalant

Inhaler or nebulizer for asthmatic conditions

Injectable

Epi-pen or similar device for severe allergic reactions to food or insect bites

Oral Medication

Oral anti-pyretic to children with a diagnosis of febrile seizures, allergic reactions, or life threatening conditions

Criteria

1. Prescription medication must be in a pharmacy prepared childproof container and labeled with:
* The name of the child
* The name of the medication
* The strength and dose of the drug
* The frequency of administration
* The authorized prescriber’s name and phone number and the date of the original prescription
* Expiration date of the medication
1. The completed **Authorization for the Administration of Medication by Day Care Personnel** form must be signed by the authorized prescriber and parent/guardian and given to the staff member when the medication is delivered. This form is then filed at the center for staff reference. A new completed form is required each time a medication is brought in. If a child has two medications, a separate form must be filled out for each medication.

**General Information**

* Only parents or guardians may give medications to staff. Parents/guardians should hand the medication, in its original container or packaging, with required labeling, to an authorized staff person only, as soon as parents/guardians arrive at the laboratory school.
* All medication will be stored in a locked cabinet, except epi-pens, which will be out of the reach of children. Each time medication is administered to a child, a written record will be completed. Parents would be notified immediately should an error be made.
* Medication will only be administered for the term of the authorized prescriber’s

order. Every medication requires a separate signed order.

* Medication will be returned to you when the term is finished, the medication is expired, or your child is withdrawn from the program. Medication will be destroyed one week after termination of the order if the parent or guardian does not pick it up.

Authorization for the Administration of Medications

by the Capital Community College Laboratory School Personnel

Authorized Prescriber’s Order (Physician, Dentist, APRN, or Physician’s Assistant)

Name of Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition for which drug is being administered during day care hours\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Drug: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of Administration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of administration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication shall be administered from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date) (date)

Relevant side effects to be observed, if any\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If there are side effects, plan for management: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Is this a controlled drug? \_\_\_\_yes \_\_\_\_no

Allergies to food or drugs? \_\_\_\_yes \_\_\_\_no If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Authorized Prescriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (type or print)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Prescriber’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization by Parent/Guardian for the administration of the above medication**

To the day care nurse, director, teacher or authorized personnel:

I hereby request that the above medication ordered by the authorized prescriber for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be administered by the nurse, director, and teacher or authorized personnel. I understand that I must supply the Childcare Center with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber. Over-the-counter medication shall be in the original container labeled by the parent with the child’s name. I understand that this medication will be destroyed if it is not picked up within one week following termination of this order. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions (not applicable for injectables).

Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_