MEDICATION FORM

55 Pa. Code §3270.133; §3280.133; §3290.133

Protocol for children requiring medication during child care hours is as follows:

o For **Prescription Medications**, the child's health care provider must complete and sign in section two below.
o Child must have **previously received a medication** before facility personnel will administer during care, excluding injectors.
o Medication only accepted in **original labeled container or box** with child's name. Epinephrine injectors MUST have 2 pens.
o Emergency Action Plans issued by physician are required for emergency-use medications.
o Please only list one child and medication per form.
o Do **NOT** put any medications in your child back pack. Please bring any medications to our office with completed form.
o Medication Forms must be renewed annually and at time of new or returning enrollment.

ONE MEDICATION PER FORM, MUST BE SIGNED AND SUBMITTED TO OUR OFFICE FOR ANY PERSONAL MEDICATION TO BE STORED AND/OR ADMINISTERED BY OUR FACILITY STAFF

Child Name ____

☐ **Prescription** – **FORM SIGNED BY HEALTH CARE PROVIDER** ☐ **Non-Prescription** – **FORM SIGNED BY PARENT**

Medication Type:

☐ Epinephrine Injector
☐ Inhaler
☐ Oral
☐ Topical

Medication Name ____
Dosage Amount ____
Frequency ____
Expiration Date __________/______________ (MM / YYYY)
Refrigeration Required Yes / No

Allergy Information: An Emergency Anaphylaxis Plan must be attached to this form for a child with allergies.

Type of Allergy: ☐ Food ☐ Environmental ☐ Other ___________ ☐ No Allergies

Allergens include ____

Special Instructions ____

Applicable Sessions child is enrolled: ☐ Summer 2018 (6/18/18-8/24/18) ☐ School 2018-2019 (9/4/18-6/14/19)

TO BE COMPLETED BY PRESCRIBING HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS

It is my understanding that the employees of a child care facility charged with the administration of this treatment/procedure during childcare hours rely on directions contained in this document. I further certify that I am the health care provider who prescribed the treatment, that the above medication and dosage information is accurate for the child named above, and that the child named above is under my supervision as a patient. A copy of the child's emergency or anaphylaxis plan for this medication, if one exists, has been attached to this form.

SIGNATURE OF HEALTH CARE PROVIDER ____

OFFICE ADDRESS ____

CONTACT PHONE ______________________________ DATE ______________________

TO BE COMPLETED BY CHILD'S PARENT/GUARDIAN

As the parent/guardian of the above named child, I agree that my child has been administered the above listed medication by a parent/guardian prior to the requested administration by Camp Curiosity, Curiosity Shoppe, and Toddler Center Inc. and that the above medication will be provided to the Camp Curiosity office with all required labels, packaging, and expiration date to be stored by Camp Curiosity on campus throughout the duration of my child's attendance. I hereby request that the treatment described above be administered to my child and release Camp Curiosity, Curiosity Shoppe, and Toddler Center Inc. and its employees from liability for any damages my child may suffer as a result of this request.

SIGNATURE OF PARENT/GUARDIAN ____

PRINTED NAME OF PARENT/GUARDIAN ____

CONTACT PHONE ______________________________ DATE ______________________