Place Photo of Child Here

Medication Exp_____

Authorization Exp _____

Grace Children's Learning Center

A Ministry of Grace United Methodist Church
9750 Wellington Rd Manassas, VA 20110
703-393-2345 phone or GCLC@umcgrace.org

Medication Authorization Consent Form

- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #20 (omit #15) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent..
- The child's health care provider MUST complete #1 through #16 for Long-Term medications or when dosage directions state "consult a physician"; the parent completes #17 through #20.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

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)

8A. Possible side effects: **see medication box** *AND/OR*
8B: Additional side effects:

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

10. 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.)

11. Reason the child is taking the medication (unless confidential by law):

12. Date medication to be discontinued:

13. Prescriber's Name	14. Prescriber's telephone number
15. Licensed authorized prescriber's signature	Date

16.

Food Allergy Symptoms & Plan

To be completed by prescriber when an Antihistamine or Epi Pen has been prescribed for a food allergy.

Prescribers please check the medication to be administered for each symptom.

□ If a food allergen has been ingested, but *no symptoms*:	□ Epinephrine	□ Antihistamine
□ Mouth Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine	□ Antihistamine
□ Skin Hives, itchy rash, swelling of the face or extremities	□ Epinephrine	□ Antihistamine
□ Gut Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□ Antihistamine
□ Throat Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
□ Lung Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
□ Heart Weak or thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
□ Other	□ Epinephrine	□ Antihistamine
□ If reaction is progressing (several of the above areas affected), give:	□ Epinephrine	□ Antihistamine

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

17. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? Yes No Write the specific time(s) GCLC is to administer the medication:

18. Parent or legal guardian's name (please print):	19. Date authorized:
20. Parent or legal guardian's signature:	

GRACE CHILDREN'S LEARNING CENTER TO COMPLETE THIS SECTION (#21 - #30)

21. Describe the special health care needs of the student as specified by the parent/guardian and the child's health care provider.

22 A. Describe any additional training, procedures, or competencies the staff identified will need to carry out this Health Care Plan. ⟹	22 B.

23 A Identify staff who will provide care to this child. **Name**	23 B. Credentials or Professional License Info

24. **Grace Children's Learning Center, GCLC**	25. Facility telephone number: **(703)393-2345**	26. (leave blank)
27. I have verified that #1-#20 are complete. My signature indicates that all information needed to give this medication has been given to us. .I understand it is my responsibility to follow the above plan. This plan was a collaboration with the child's parent & medical professional.		
28. Authorized child care provider's name (please print):		29. Date received from parent:
30. Authorized child care provider's signature:		