Parks and Recreation Department
540-665-5678
Fax: 540-665-9687
www.fcprd.net
Email: fcprd@fcva.us

RE:FCPRD Written Medication Consent Form
July 2014

Dear basicREC/ CAMP basicREC Parents/ Guardians:
Below is a copy of our MEDICATION POLICY- If your child(ren) needs to have one of these medications on site for emergency use you will need to have the MEDICATION FORM (*attached*) filled out by you and your child's physician. Once this form is complete you can return it to the program site staff along with the required medication. Please understand that we cannot keep or administer any of the outlined medications without this form being completed.

Frederick County Parks and Recreation Department (FCPRD) staff must be MAT certified to administer the following emergency medications; physician prescribed asthma inhaler, glucagon (orally or rescue injections only) and EpiPen.

In order for a parent to leave any of the above medications with us they must have their child's physician fill out the VA STATE mandatory authorization medication form a.k.a. FCPRD Written Medication Consent Form. *Without the form, we do not take the medication.*

Children with diabetes may self test and use an injection pen or pump to administer their insulin. FCPRD staff will not test, determine when a test is needed, or administer insulin. If applicable, parents will need to supply a sharps container and dispose of used testing strips and or injection pens. Before your child can start the program a meeting must take place with the Recreation Technician (site supervisor) and/or the basicREC Program Manager to go over your child's daily plan of action.

*Children are not permitted to transport medications to and/or from the home/school. An original prescription must be kept on site with FCPRD staff during the program. *If applicable, the only exception is during the summer. FCPRD staff will let participants transport their medication to and from CAPM basicREC to any premium camps they may be enrolled in.**

The FCPRD Written Medication Consent Form *will be valid for one year June to May . However if applicable, we must ask the parent to look over the form (that we have on file) at the start of the school year to confirm that there are no changes. CHANGES CAN ONLY BE MADE BY A PHYSICIAN!*

If you should have any questions regarding the form, please call me at 540-665-5678

Sincerely,
Jason R. Brown
basicREC Manager
jbrown@fcva.us

MAT Handout 2.4

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) 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 #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

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: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: Additional side effects: _____

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

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe): _____

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

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 situations when medication should not be administered.) _____

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

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-#34 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 #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:
Required for Long-Term medication or when dosage directions state "consult a physician".

This is a double-sided form

MAT Handout 2.4

Written Medication Consent Form

PARENT/GUARDIAN MUST 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 prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name) .

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature: _____	

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

24. Provider/Facility name:	25. Facility telephone number:	26. County
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 child day program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

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

31. I, parent/legal guardian, 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 or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child._____
34. Licensed Authorized Prescriber's Signature:
35. 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 by which you expect the pharmacy to fill the updated order. DATE:_____ By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature:

This is a double-sided form