MAT IS Handouts

O6/30/19 Version

Medication Administration Training (MAT) Overview

The Medication Administration Training (MAT) course is approved by the Board of Nursing and Virginia Department of Social Services (VDSS). It is designed to teach you best practice techniques for giving medication to children in your care.

- In this course, you'll learn to give medication by these routes:
  - On the skin (topically)
  - By mouth (orally)
  - Inhaled (the child breathes it in through his nose or mouth)
  - By putting it in the ear
  - By putting it in the eye
  - By using an epinephrine auto-injector, like EpiPen®, to give the epinephrine

- **Please note:** to be able to administer insulin and glucagon or emergency rectal medications, individuals must successfully complete the MAT course and one or both of the following courses specific to the child's needs: 1) *MAT Diabetes Care in Child Care Settings*, and/or 2) *MAT Administration of Emergency Rectal Medications in Child Care Programs*, and/or *3) MAT Epilepsy Care*. Information about these courses can be obtained by visiting the MAT website at: http://www.medhomeplus.org/MAT/. Be aware that the child's individual health care plan may also include additional child-specific training requirements.

***To successfully complete this course, you must*:**

- Be at least 18 years old
- Pass a written test and skills demonstrations
- Be able to read and write in English well enough to understand the health care providers' written instructions and the parents/caregivers' written permissions
- Be able to write down that you have given the medication
- Be able to read, understand and follow step-by-step instructions for the safe administration of medication
- Have current certification in first aid and cardiopulmonary resuscitation (CPR)

Competency Based Training

The MAT course is a competency based training. You will be tested to make sure you understand and can put into practice the information presented. All of the information you are tested on in this course is included in the MAT videos you will see today and on the MAT handouts. You are encouraged to use all of the MAT handouts when completing written tests and during the skills demonstrations.

Written Test:

- You can use all of the MAT handouts when you take the test.
- The test is 20 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 version of the 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 demonstrate your ability to:

- Match the ***Five Rights*** of safe medication administration.
- Safely give medication by one of the routes listed here:
  - By mouth (orally)
  - Inhaled into mouth or nose
  - In the ear
  - In the eye

  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 skills demonstration 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.

Your MAT trainer will watch you complete each of these skills. If you don't pass on your first try, you can try again. You will demonstrate a different route for your second attempt. If you don't pass on your second try, you must take this course again to become MAT Certified.

Regulations

Regulations create the basic structure for the way child day programs and private schools operate. They establish minimum standards for the quality of each program. As a child day program provider, you should know what is required by law and regulation. Handout 1.2 gives the links to the appropriate regulations or regulatory guidance documents for each type of child day program and for private schools.

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. **You can download and/or print the complete MAT Handout set or any individual Handout any time you wish from the front page of the MAT Online Learning Center (mat-elearning.medhomeplus.org)**.

MAT Curriculum Forms

Your MAT handouts include forms approved by the Virginia Board of Nursing and VDSS. These forms are updated periodically. You can check the MAT Online Learning Center anytime for the most current version.

Child Day Programs in Virginia

A **child day program** in Virginia is a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and well-being of a child under the age of 13 for less than a 24-hour period. The Virginia Department of Social Services (VDSS), Division of Licensing Programs monitors the activities of licensed and regulated child day programs in Virginia.

Child Care Modalities

Child day programs can occur in many different settings. For the purposes of MAT, we refer to these different types of child day program settings as child care modalities.

To find the applicable regulations and code references **for each type of child care modality,** as well as other useful information, including technical assistance, visit the VDSS Web site at: http://www.dss.virginia.gov/family/cc/index.cgi and click on the specific child care modality.

Summary information for each type of child care modality:

Licensed Child Day Programs

Child Day Center (CDC): A child day program offered to (i) two or more children under the age of 13 in a facility that is not the residence of the provider or of any of the children in care or (ii) 13 or more children at any location. There are currently 14 exemptions to licensure.

Short-Term Child Day Center (CCS): Short-term child day centers are licensed child day centers that operate for less than 4 months in the year.

Family Day Home (FDH): A child day program offered in the residence of the provider or the home of any of the children in care for one through 12 children under the age of 13, exclusive of the provider's own children and any children who reside in the home, when at least one child receives care for compensation. Family day homes serving six through 12 children, exclusive of the provider's own children and any children who reside in the home, shall be licensed. However, no family day home shall care for more than four children under the age of two, including the provider's own children and any children who reside in the home, unless the family day home is licensed or voluntarily registered.

Family Day System (FDS): Any person who approved family day homes as members of its system; who refers children to available family day homes in that system; and who, through contractual arrangement, may provide central administrative functions including but not limited

to, training of operators of member homes; technical assistance and consultation to operators of member homes; inspection, supervision, monitoring , and evaluation of member homes; and referral of children to available health and social services.

Regulated/Unlicensed Child Day Programs

Religiously Exempt Child Day Center (CCE): A child day center operated under the auspices of a religious institution. If a child day center operated by or conducted under the auspices of a religious institution chooses not be licensed, certain documentation must be filed annually with the Virginia Department of Social Services. In addition, the Code of Virginia (Code) outlines the other requirements that exempt child day centers must meet.

Registered Family Day Home (VR)*:** Any family day home that has met the standards for ***voluntary registration for such homes pursuant to regulations adopted by the Board of Social Services and that has obtained a certificate of registration from the Commissioner.

Certified Preschool (CNS): A preschool program operated by a private school that is accredited by a statewide accrediting organization (or another accrediting organization recognized by the Board of Education) to be exempt from licensure. In order for preschool and nursery school programs operated by accredited private schools to be certified, certain information must be filed with VDSS before the beginning of the school year or calendar year. That information must be filed annually thereafter.

Approved Child Day Programs

***Local Ordinance Approved (LOA)*:** There are currently three localities (Alexandria, Arlington and Fairfax) that regulate child care facilities as allowed by the Code.

***Department of Education Approved*:** Education and care programs provided by public schools and regulated by the Board of Education using regulations that incorporate or exceed the regulations for child day centers licensed by VDSS.

For Providers:

How to Create a Free Individual Email Account

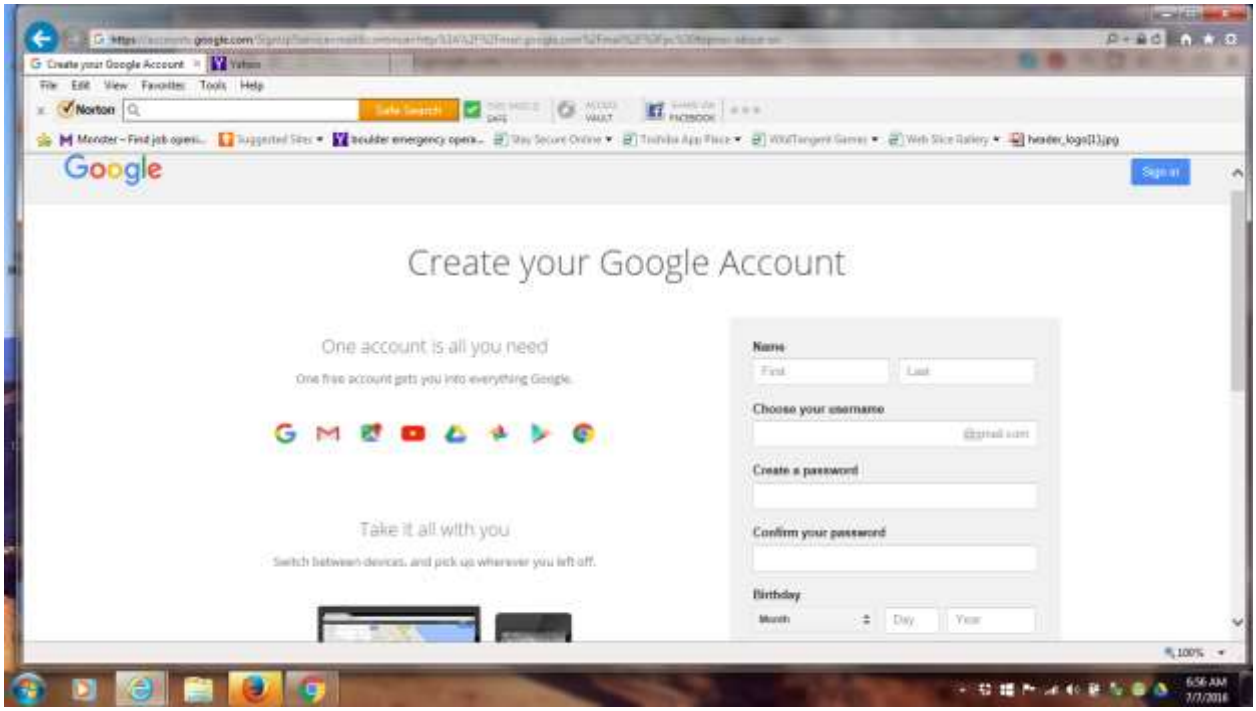
If you don't have an individual email account, don't worry – it's free and easy to get one!

If you have a cellphone that accepts text messages, it takes just a few minutes to create a new, free, individual email account. You'll be able to access this email account from any Internet-connected computer, iPad, tablet or smartphone, by logging in with the username and password you create when you set up the account. If you don't share the username and password for this account with anyone, it is quite secure.

We've provided instructions here on how to create your own new Gmail account. These accounts are managed by Google, one of the best providers of free email accounts. Yahoo (www.yahoo.com) is another recommended provider of free email accounts, and their new account creation process is very similar.

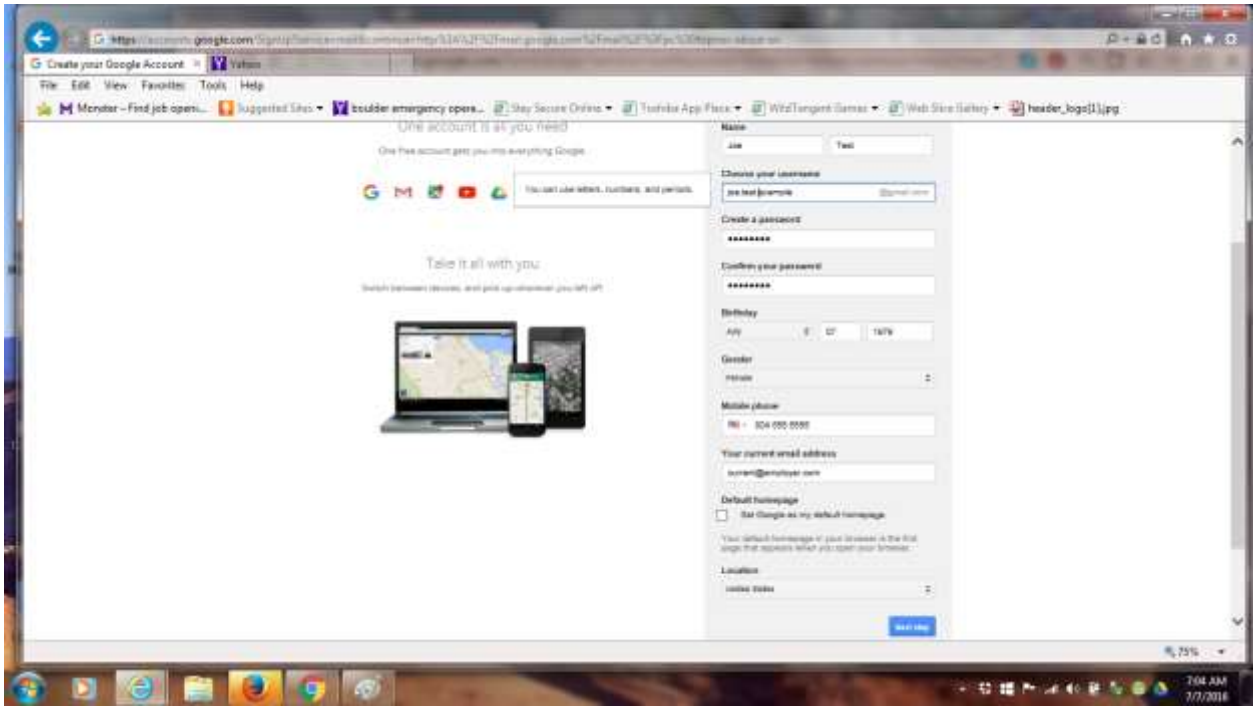
Let's get started!!

1) **Go to accounts.google.com** and you'll see a registration form either identical or very similar to the one below.

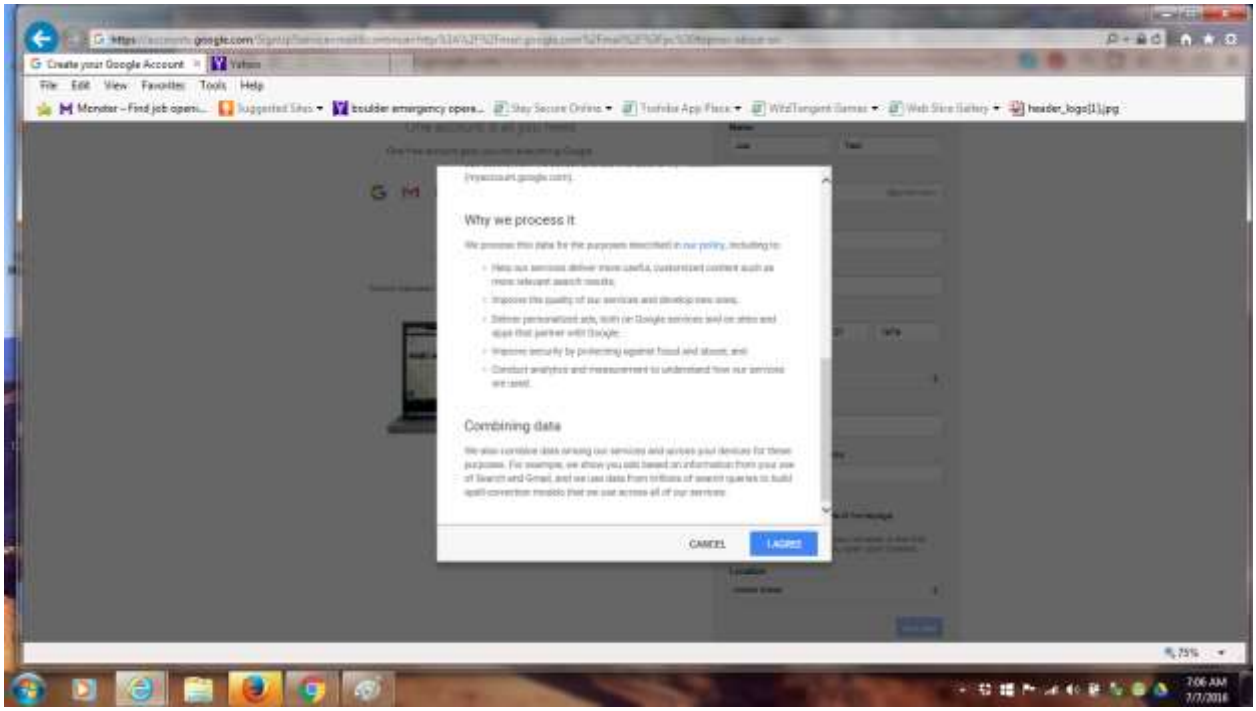


2) **As mentioned above,** you must have either a cellphone that receives texts or a current email address to create a new Gmail email account.

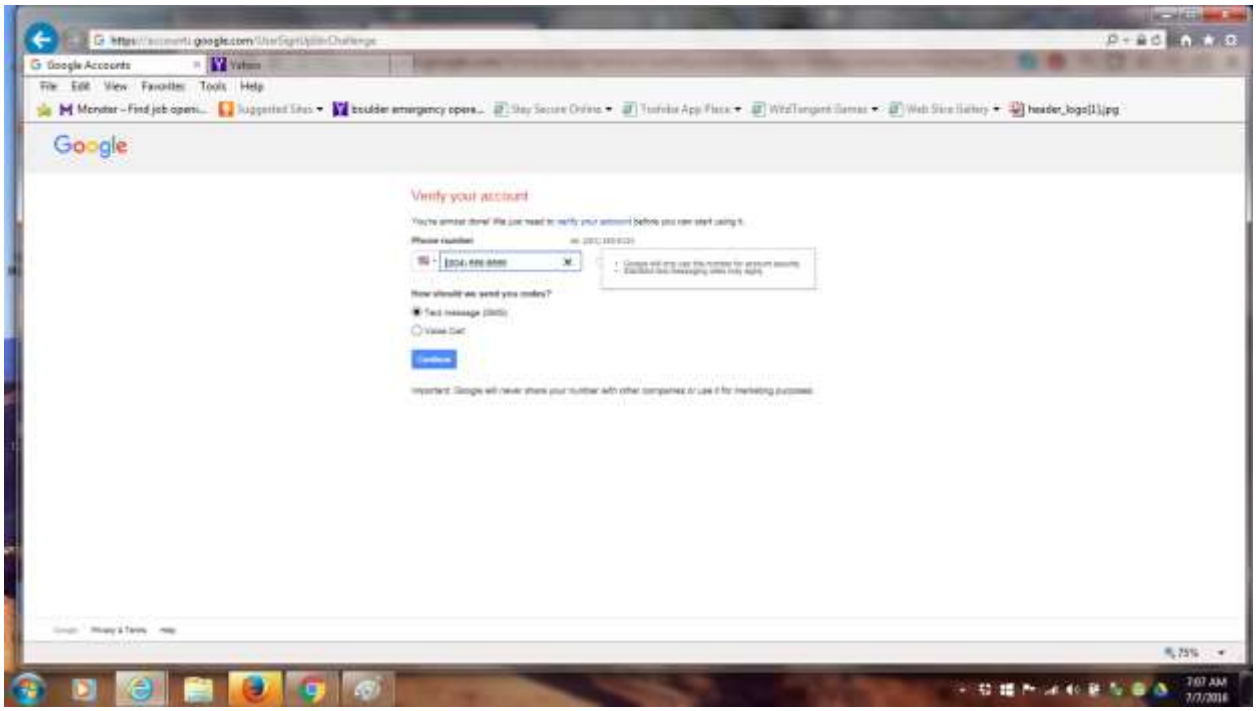
3) **Fill in this new account form and click the Next Step button** to submit it. If you don't have a current email address, leave that blank, but you will definitely need to enter a cellphone number that accepts texts in that case.



4) Click the "I agree" button to agree to their terms



5) **Follow the onscreen instructions to verify your account –** they will immediately text a code to your cellphone, and you enter that code into a blank on the screen where you are creating the account. This verifies that they have a second means of contacting you if needed.



THAT'S IT! Now you can go to accounts.google.com anytime on any Internet-connected device, log in, click the envelope icon, and use this new email account to send and receive emails securely!

Matching the Five Rights

1. *Right child*

- Match the child's first and last names on the Consent Form with the first and last names on the pharmacy label or package. Then match this name to the child you are about to give medication to.
- 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 who works with the child to tell you the child's name.

2. *Right medication*

- Match the medication name on the pharmacy label or package to the medication name on the Consent Form. Be careful, because names of medication can sound alike and be spelled similarly, but be very different medications.
- The strength of the medication must also match. 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).
- If the child's healthcare provider has specified brand name medicine on the Consent Form, generic medication cannot be accepted as a substitute. If the child's health care provider wrote both the generic name and the brand name on the Consent Form, you can accept either the generic or brand name medication from the parent.

3. *Right dose*

- Match the dose written on the Consent Form with the dose written on the pharmacy label or package. If you are about to give the medication, match this dose to the dose you are about to give.
- The dose is how much medication to give. For example, the dose could be one tablet, 5 mL, 2 teaspoons or one drop.
- Give the exact amount of the medication specified on the Consent Form and the pharmacy label.
- If the medication is a liquid, make sure the measurement tool that the parent supplied, such as a dosing spoon, oral syringe, or medicine cup, has the same unit of measurement (such as mLs, teaspoons, etc) on it that is written on the Consent Form.

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.
- Match the route written on the Consent Form with the route written on the pharmacy label or package. If you are about to give the medication, match this route with the way you are about to give the medication.
- Remember, some routes include "left" or "right", such as "left eye", "right ear", etc. Be careful to give the medication in the correct place!
- Always ask if you don't understand how to give the medication correctly by the route written.

5. Right Time

- When a child arrives at your program, check with the parent to find out if the child got any medication before arriving. If so, write this dose on the correct Log of Medication.
- Before preparing to give a dose, check the child's Log of Medication Administration to see if this dose has already been given by another caregiver.
- To match the Right Time, match the time written on the Consent Form with the time written on the pharmacy label or package with the time the dose is actually given.
- To find the Right Time, remember, medication can be scheduled to be given at a specific time, or have instructions that tell you what symptoms mean that the child needs the medication ("as needed"). For "as needed" medications, the Consent Form and medication label will say how much time there must be between doses, and the maximum number of doses the child can get in one day.
- The **Right Time** to give **scheduled medications** is up to 30 minutes before or up to 30 minutes after the time written on the Consent Form.

- The **Right Time** to give **"as needed" medications** is when the child is showing the symptoms specified on the Consent Form, ***AND the dose is not too soon after the last dose AND will not exceed the total doses the child can get in one day.***
    - ***The minimum amount of time between doses and the maximum number of doses allowed in one day might be stated in Item 7B or in the Special Instructions section in the Consent Form and/or on the pharmacy label or medication package. Always look for this information for "as needed" medications! .***

Be Safe: Match the Five Rights Every Time You Give Medication

Medication Consent Form

Handout 2.2

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **This form is not required for over-the-counter diaper cream, sunscreen, insect repellant, lotion, lip balm or Vaseline.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-18 for prescription or OTC medication to be given more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

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**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: □ See package insert (parent must supply) *AND/OR* 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):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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 require health and related services of a type or amount beyond that required by children generally?
□ No □Yes If you checked yes, complete #25 and #27 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 #26 and #27 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 12 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 (more than 10 working days) prescription medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to (child's name) .	
20. Parent or legal guardian's name (please print):	21. Date authorized:
22. Parent or legal guardian's signature:	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:	29. Facility Phone Number:
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print):	31. Date received from parent:
32. Authorized child care provider's signature:	

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 **Medication Consent Form** on the next page and match each one with the **Five Rights** on the medication package.

Drug Facts LOTB0273 EXP11/XX

Active ingredient	Purpose
Benzocaine 7.5%	Oral pain reliever

Use 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.

Warnings

Allergy alert: 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

Do not use ■ more than directed ■ for more than 7 days unless directed by a physician or healthcare provider

When using this product ■ fever and nasal congestion are not symptoms of teething and may indicate the presence of infection. If these symptoms persist, consult your physician.

Stop use and ask a physician if ■ sore mouth symptoms do not improve in 7 days ■ irritation, pain or redness does not go away ■ swelling, rash or fever develops

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

Directions ■ 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

Other information do not use if tube tip is cut prior to opening

Inactive ingredients cellulose gum, flavor, gelatin, mineral oil, pectin, petrolatum, polyethylene glycol, red 40, sodium saccharin

Questions or comments? call us at **1-800-952-5080** M–F 9am–5pm ET or visit our website at **www.orajel.com**

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

MAT Medication Consent Form

Handout 2.3 Consent

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

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** (including strength): **Baby Orajel 7.5%**	5. **Amount/DOSAGE to be given**: **Small pea-size amount**	6. **ROUTE of administration**: **Oral on gums**

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

Parent's signature approving Specific Time(s)_____

OR

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**

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: **X** See package insert (parent must supply) *AND/OR* 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.) **N/A**

11. **Reason the child is taking the 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 require health and related services of a type or amount beyond that required by children generally?
□ No □Yes If you checked yes, complete #25-#27 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?
X No □ Yes If you checked yes, complete #26-#27 on the back of this form.

14. Date consent form completed: **9/29/XX**	15. Date to be discontinued or length of time in days to be given (*this date cannot exceed 12 months from the date authorized or this order will not be valid*):

16. **Prescriber's name** (please print): **Dr. Margaret Valens**	17. **Prescriber's telephone number**: **(718) 555-2345**

18. **Licensed authorized prescriber's signature**: **X** *Margaret Valens, M.D.*
Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

Medication Consent Form

Handout 2.3 Consent

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Missy Franklin** (child's name) .	
20. Parent or legal guardian's name (please print): **Anne Franklin**	21. Date authorized: **10/1/XXXX**
22. Parent or legal guardian's signature: **X** *Anne Franklin*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child. **See individual health care plan**
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: **(914) 555-2784**
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Carla Carson**	31. Date received from parent: **10/2/XXXX**
32. Authorized child care provider's signature: X. *Carla Carson*	

MAT Medication Consent Form

Handout 2.3 KEY

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:** **Missy Franklin**	2. Date of birth: **4-3-XX (6 months old)**	3. Child's known allergies: **ne known**

Child

Dose

4. **Name of MEDICATION** (including strength): **Baby Orajel 7.5%**	5. **Amount/DOSAGE to be given**: **Small pea-size amount**	6. **ROUTE of administration**: **Oral on gums**

Medication

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

*Parent's signature approving Specific Time(s)*_____

OR

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**

Time

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: **X** See package insert (parent must supply) *AND/OR* 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.) **N/A**

11. **Reason the child is taking the 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 require health and related services of a type or amount beyond that required by children generally?
□ No □Yes If you checked yes, complete #25-#27 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?
X No □ Yes If you checked yes, complete #26-#27 on the back of this form.

14. Date consent form completed: **9/29/XX**	15. Date to be discontinued or length of time in days to be given (*this date cannot exceed 12 months from the date authorized or this order will not be valid*):

16. **Prescriber's name** (please print): **Dr. Margaret Valens**	17. **Prescriber's telephone number**: **(718) 555-2345**

18. **Licensed authorized prescriber's signature**: x *Margaret Valens, M.D.*
Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

MAT Medication Consent Form

Handout 2.3 KEY

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Missy Frankin** (child's name) .	
20. Parent or legal guardian's name (please print): **Anne Franklin**	21. Date authorized: **10/1/XXXX**
22. Parent or legal guardian's signature: **X** *Anne Franklin*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child. **See individual health care plan**
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: **(914) 555-2784**
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Carla Carson**	31. Date received from parent: **10/2/XXXX**
32. Authorized child care provider's signature: X. *Carla Carson*	

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 **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, Richmond, VA 23000
Rx#: 8145973-02 Tx: 8063264

Jose Martinez DOB: 11/30/XX
(914) 554-1984
461 Park Place, Richmond , VA 23000

albuterol (90mcg/inh)
(generic form of Ventolin®)
Give two puffs by oral inhaler as needed for shortness of breath. May give every four hours up to three doses per day.

Prescriber: **Nancy Wallace MD (914) 564-9832**
221 Stream Place, Richmond, NY23000
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 Medication: _____
2. Right Time:_____
3. Right Dose:_____
4. Right Route:_____
5. Right Child:_____

MAT Medication Consent Form

Handout 2.3 Case 2 Consent

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:** **Jose Martinez**	2. Date of birth: **11/30/xxxx (6 years old)**	3. Child's known allergies: **Dust, pollen and bee stings**

4. **Name of MEDICATION** (including strength): **albuterol 90 mcg/ inhalation inhaler**	5. **Amount/DOSAGE to be given**: **2 puffs** – at least 4 hrs between doses, max of 3 doses/day	6. **ROUTE of administration**: **Inhaled by mouth**

7A. **FREQUENCY**: _____ or **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

Parent's signature approving Specific Time(s) _____

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters). **Give when Jose has shortness of breath**

8. **Possible side effects**: X See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) _____
Give every 4 hours as needed. Do not give more than 3 times a day.

11. **Reason the child is taking the 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 require health and related services of a type or amount beyond that required by children generally?
□ No X Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 on the back of this form.

14. Date consent form completed: **7/15/CY**	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid): **7/15/NY**

16. **Prescriber's name** (please print): Nancy Wallace, M.D.	17. **Prescriber's telephone number**: (804) 564-9832

18. **Licensed authorized prescriber's signature**: *Nancy Wallace, M.D.*
Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Jose Martinez** (child's name) .	
20. Parent or legal guardian's name (please print): **Anne Martinez**	21. Date authorized: **7/15/CY**
22. Parent or legal guardian's signature: *Anne Martinez*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child. **See individual health care plan**
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature: *Nancy Wallace, M.D.*

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: **(804) 555-2784**
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Carla Carson**	31. Date received from parent: **7/15/CY**
32. Authorized child care provider's signature: *Carla Carson*	

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 **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, Richmond, VA 23000
Rx#: 8145973-02 Tx: 8063264

Child **Jose Martinez** **DOB: 11/30/XX**
(914) 554-1984
461 Park Place, Richmond , VA 000

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

Route

Time

Dose **Give two puffs by oral inhaler as needed for shortness of breath. May give every four hours up to three doses per day.**

Prescriber: **Nancy Wallace MD (914) 564-9832**
221 Stream Place, Richmond, NY23000
Refillable: 0 times QTY:1 R.Ph. Init: RSL
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/X

1. Right Medication: *albuterol 90 mcg/inh*
2. Right Time: *When Jose has shortness of breath (adding "every four hours" is also acceptable, but the participant must state "when the chil has shortness of breath")*
3. Right Dose: *2 puffs*
4. Right Route: *Oral inhaled*
5. Right Child: *Jose Martinez*

Exercise: "Right Time" for As Needed Medication

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

***Case Study* 1:** Your name is Cindy Smith. Today is October 2. Ruby Sanchez is a 3 year old in your program. She has an ear infection and is receiving antibiotics. In addition, her doctor has advised her parents to give her Children's Tylenol as needed for ear pain. Ruby's mother has provided a completed **Consent Form** for Children's Tylenol, as well as a bottle of Children's Tylenol with instructions below on the package. Ruby's mother has added any doses she has given to today's log.

It is 9:00am and Ruby is complaining that her ear really hurts. Using Ruby's Consent Form, today's Log of Medication and the medication package instructions, answer the following questions:

1. **Is this the "Right Time" to give Ruby this medication? Why or why not?** *No, this is not the right time to give this dose because even though Ruby has the symptoms that indicate she needs the medication, it is only 3 hours since her last dose, and the package instructions say to give doses 4 hours apart as needed.*

2. **If she continues to have ear pain, when is the NEXT time she can have a dose of this medication?** *10:00 am, 4 hours after her last dose.*

Case Study 2: Today is October 3. Ruby's mother has added any doses she has given to today's log. It is 4:00pm and Ruby says her ear is hurting again. Using the documents provided, answer the following questions:

1. **Is this the "Right Time" to give Ruby this medication? Why or why not?** *Yes, this is the right time to give this dose, because Ruby has the symptoms that indicate she needs the medication, it's 4 hours since her last dose, and she has not already had the 5 doses she can have in one day.*

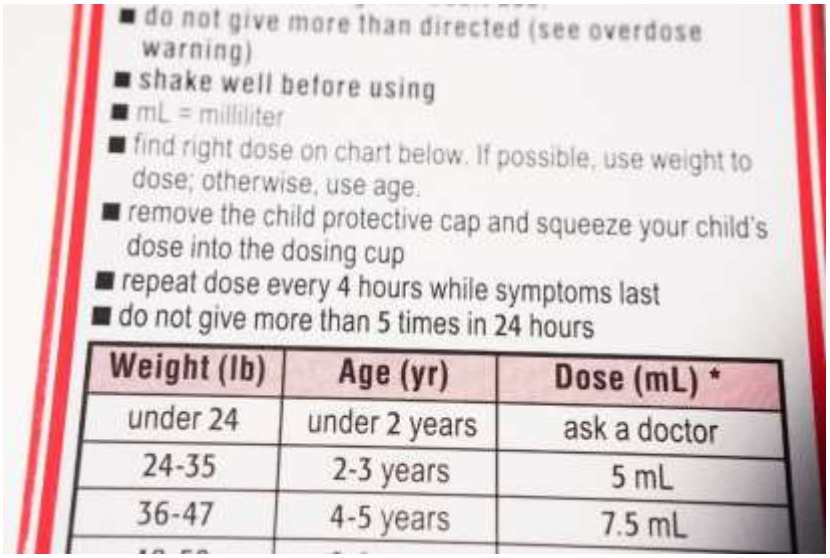
2. **If she continues to have ear pain, when is the NEXT time she can have a dose of this medication?** *1:00 am tomorrow, because THIS dose will be her 5th dose today, the maximum number of doses she can have in 24 hours. So she can't have any more doses today.*

Case Study 3: Today is October 4. It is 10:00am and Ruby says her ear has started hurting again. Ruby's mother has added any doses she has given to today's log. Using the documents provided, answer the following questions:

1. **Is this the "Right Time" to give Ruby this medication? Why or why not?** *Yes, this is the right time to give this dose, because Ruby has the symptoms that indicate she needs*

the medication, it's been more than 4 hours since her last dose, and she has not already had the 5 doses she can have in one day.

2. **If she continues to have ear pain, when is the NEXT time she can have a dose of this medication?** *After this 10:00am dose, the next dose she can have is 4 hours later at 2:00pm.*



Medication Consent Form

Handout 2.4

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **This form is not required for over-the-counter diaper cream, sunscreen, insect repellant, lotion, lip balm or Vaseline.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-18 for prescription or OTC medication to be given more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:** Ruby Sanchez	2. Date of birth: **06/04/xx (age 3)**	3. Child's known allergies: **none**

4. **Name of MEDICATION** (including strength): **Children's Tylenol**	5. **Amount/DOSAGE to be given**: **5 mL**	6. **ROUTE of administration**: **Oral**

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters). **Ear pain**

8. **Possible side effects**: X See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) **see package instructions**

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

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
X No □Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 on the back of this form.

14. Date consent form completed: **10/2/CY**	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid): **10/8/CY**

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**:

18. **Licensed authorized prescriber's signature**:

Required for long-term (more than 10 working days) prescription medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Ruby Sanchez** (child's name) .	
20. Parent or legal guardian's name (please print): **Rose Sanchez**	21. Date authorized: **10/2/CY**
22. Parent or legal guardian's signature: ***Rose Sanchez***	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **Cindy Smith**	29. Facility Phone Number: 222-333-4444
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print):	31. Date received from parent: **10/2/CY**
32. Authorized child care provider's signature: ***Cindy Smith***	

MAT Log of Medication Administration

Handout 2.4

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD'S NAME __Ruby Sanchez____________ MEDICATION (and strength)____**Children's Tylenol**__________________

COMPLETE FOR ALL DOSES GIVEN					**COMPLETE WHEN SIDE EFFECTS ARE NOTED**		**COMPLETE FOR 'AS NEEDED' MEDICATION ONLY**		**Controlled Substances ONLY**
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Parents notified? and Time	The symptoms the child had that indicated that the medication was needed	Parents notified? and Time	Total Doses Given and Remaining
10/2/CY	**5 mL**	**Oral**	**6:00** AM **X** PM□	**Rose Sanchez** ***Rose Sanchez***		Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes□ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	

Log of Medication Administration **Handout 2.4**

Complete this section for any medication dose that was not given as written on the child's medication consent form.

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

MAT Log of Medication Administration

Handout 2.4

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD'S NAME __Ruby Sanchez_____ MEDICATION (and strength)___**Children's Tylenol**_____

COMPLETE FOR ALL DOSES GIVEN					**COMPLETE WHEN SIDE EFFECTS ARE NOTED**		**COMPLETE FOR 'AS NEEDED' MEDICATION ONLY**		**Controlled Substances ONLY**
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Parents notified? and Time	The symptoms the child had that indicated that the medication was needed	Parents notified? and Time	Total Doses Given and Remaining
10/3/CY	**5 mL**	**Oral**	**1:00** AM **X** PM□	**Rose Sanchez** ***Rose Sanchez***		Yes □ No□		Yes □ No□	
10/3/CY	**5 mL**	**Oral**	**5:00** AM X PM□	**Rose Sanchez** ***Rose Sanchez***		Yes □ No□		Yes□ No□	
10/3/CY	**5 mL**	**Oral**	**9:00** AM X PM□	**Cindy Smith** ***Cindy Smith***		Yes □ No□		Yes □ No□	
10/3/CY	**5 mL**	**Oral**	**1:00** AM□ PM X	**Cindy Smith** ***Cindy Smith***		Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	

Log of Medication Administration **Handout 2.4**

Complete this section for any medication dose that was not given as written on the child's medication consent form.

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

Log of Medication Administration

Handout 2.4

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD'S NAME __Ruby Sanchez____________ MEDICATION (and strength)____**Children's Tylenol**__________________

COMPLETE FOR ALL DOSES GIVEN					COMPLETE WHEN SIDE EFFECTS ARE NOTED		COMPLETE FOR 'AS NEEDED' MEDICATION ONLY		Controlled Substances ONLY
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Parents notified? and Time	The symptoms the child had that indicated that the medication was needed	Parents notified? and Time	Total Doses Given and Remaining
10/4/CY	**5 mL**	**Oral**	**1:00** AM **X** PM□	**Rose Sanchez** ***Rose Sanchez***		Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes□ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	

Log of Medication Administration **Handout 2.4**

Complete this section for any medication dose that was not given as written on the child's medication consent form.

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

Medication Effects

Medication is given for many reasons. If it works right, it has the "desired effect."
Medication can be given to:

- **Prevent illness** (such as getting the polio vaccine so you don't get polio)
- **Control health problems** (such as taking medication every day to help prevent seizures)
- **Cure an illness** (such as taking an antibiotic to get rid of an ear infection)
- **Reduce symptoms (**such as taking Tylenol® to lower a fever)

Taking medication has effects on the child's body. These effects can be wanted (desired effects), 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 (or guardian).

Types of Undesired/Side effects	Action to Take
Severe allergic reaction Severe hives, swelling, especially lips and face, trouble breathing, severe vomiting, diarrhea or stomach cramping, racing heart, "passing out" **Adverse effect** Seizures, chest pain, highly unusual behavior, severe dizziness	**Call 911 right away** Notify parent as soon as possible
Mild allergic reaction Itchy red skin, slight localized rash, itchy/watery eyes, sneezing, runny, stuffy or itchy nose, an itchy feeling in the mouth or throat	**Notify parent immediately** Encourage parent to contact the child's health care provider for instructions If the reaction becomes severe, contact 9-1-1 immediately
Mild side effect Upset stomach, sleepiness (drowsiness), diarrhea, constipation, trouble sleeping, irritability, nervousness, dry mouth, headache, nausea/vomiting, changes in appetite	**Notify parent** by the end of the day

Log of Medication Administration

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD'S NAME ________________ MEDICATION (and strength)____

COMPLETE FOR ALL DOSES GIVEN					COMPLETE WHEN SIDE EFFECTS ARE NOTED		COMPLETE FOR 'AS NEEDED' MEDICATION ONLY		Controlled Substances ONLY
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Parents notified? and Time	The symptoms the child had that indicated that the medication was needed	Parents notified? and Time	Total Doses Given and Remaining
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes□ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	

Log of Medication Administration **Handout 3.2**

Complete this section for any medication dose that was not given as written on the child's medication consent form.

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

Medication Routes Covered in This Course and Special Authorizations

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

- On the skin (topically)
- By mouth (orally)
- Inhaled through the mouth or nose
- By putting it in the ear
- By putting it in the eye
- By using an auto-injector

If a child in your program needs medication given by routes not covered in this course, if you are MAT Certified, in some situations, you can get authorization to do this. The chart below outlines these situations:

	Course or Training Providing Authorization	Evidence of Successful Completion
Rectal Medications	MAT Rectal online course or MAT Epilepsy course	Applicable Course Certificate
Diabetes – Insulin, Glucagon	MAT Diabetes course	MAT Diabetes Certificate
Inhaler, nebulizer or epinephrine auto-injector devices not covered in this course	**Additional child-specific training*** on the specific device you will use. The MAT AuviQ online course is available for that device.	AuviQ Completion Certificate, or for other additional training*, use the **Special Authorizations and Individual Health Care Plan form (Handout 3.7)** to document the specific additional training received and the date you completed it.
Any other route *(such as G-Tube)*	**Can be authorized ONLY IF APPROVED IN WRITING BY LICENSING.** Consult your Licensing Representative or Inspector, asking for written permission to get authorization for the specific route requested through additional training*.	Document the specific additional training received and the date you completed it using the **Special Authorizations and Individual Health Care Plan form**

*__Additional child-specific training__ is whatever the parent and healthcare provider decide is necessary for the MAT-Certified provider to be prepared to safely give medication by this route/device. It can be as simple as a demonstration by the parent or healthcare provider.

Medication Routes: Additional Information

Route	Forms of the medication	How fast does the medication start working?	Special Information
#1) Topical medication is put on the skin .	Medication put on the skin can be a: • cream • lotion • ointment • gel • aerosol	Depends on the medication Topical medication should be applied to dry, intact skin unless otherwise instructed.	
Medicated patches are patches with medication in them that are put on the skin and kept on the skin for a period of time.	Medication comes in the form of a patch.	Small amounts of medication are absorbed slowly, in a controlled manner, over a period of time.	Patches remain on the skin and allow small amounts of medication to be absorbed slowly, in a controlled manner, over a period of time. Medicated patches for children are currently not common but advances in technology may allow for many medications to be administered to children using this route. May be referred to as transdermal patches. Band-Aids® are <u>not</u> considered medicated patches because they do not allow for slow controlled medication absorption over a period of time.

Route	Forms of the medication	How fast does the medication start working?	Special Information
#2) Oral medication is given by mouth.	Medication taken by mouth can come in many forms, including: • tablets • capsules • liquids • sprinkles (small granules that can be sprinkled onto food or onto the tongue) • strips/melts (medication that is placed on the tongue or in the mouth, where it dissolves) • gels that are rubbed into the gums or inside the mouth	This time can vary due to many factors. Some things that can affect how fast the medication starts working: • Amount of food in stomach • Most tablets should be swallowed whole • Activity level A pill cutter should be used if it becomes necessary to split a pill in half. Never use household utensils or items to cut	Usually starts working in about 30-60 minutes. Do not crush, chew or cut apart capsules unless directed by a health care provider.Capsules must be swallowed whole unless otherwise instructed by the health care provider. Liquids are most commonly given to children under five who cannot safely swallow a pill Rapid absorption; effects usually noted within 10 minutes. Sprinkles are the contents of a capsule. Sprinkles can come in small packets or in capsules that can be opened and poured out.

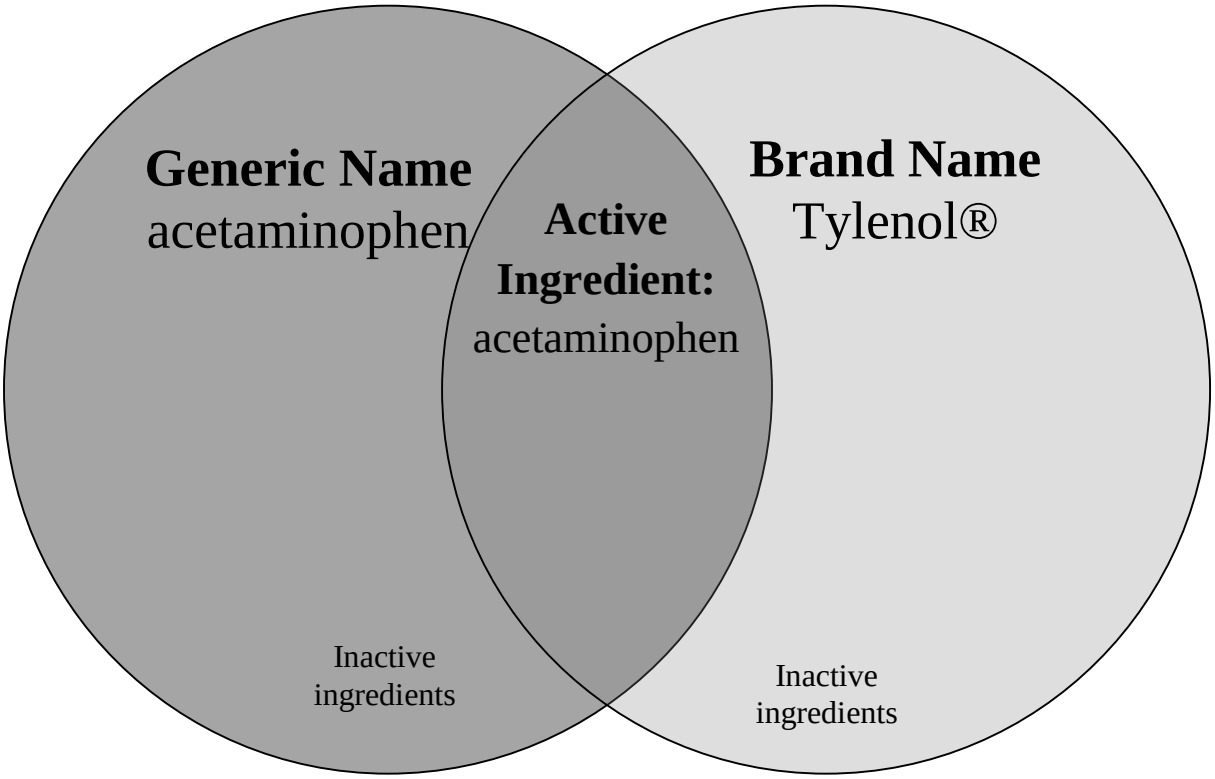
Route	Forms of the medication	How fast does the medication start working?	Special Information
#3) Inhaled medication is breathed in through the nose or mouth	Medication breathed in through the nose can be given by: • spray • drop	Usually starts working in about 10 to 15 minutes	Children may complain of an unpleasant taste in their mouth after receiving nasal medication
	Medication breathed in through the mouth can be given by: • inhaler, such as metered-dose inhaler or dry powder inhaler • nebulizer, a machine that changes liquid medication into a mist that can be breathed in	Usually starts working in about 5 to 15 minutes	* Many children need to use a spacer device to help them use a metered dose inhaler correctly. *Children under five usually use a nebulizer instead of an inhaler because the child does not need to use any special breathing techniques in order to get the medicine into the respiratory tract. *Dry powder inhalers come in a pre-measured dose. Each click of the inhaler administers one dose of the medication.
#4) Eye medication is placed into the eye.	Medication put into the eye can be: • drops • ointment	Usually right away	
#5) Ear medication is placed into the ear	Medication comes in a liquid to be dropped into the ear.	Depends on the medication	Most ear medication is given to prevent or treat infections of the ear
#6) Auto-injector for giving the medication epinephrine to a child having a serious allergic reaction.	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.	Usually right away	Child care providers may only administer epinephrine using an auto- injector device to a child that has been prescribed the medication by a health care provider for the treatment of a serious allergic reaction, such as anaphylaxis. Children may appear better quickly, but still require emergency treatment and care once epinephrine is administered.

TYPES OF MEDICATION

Medication Types	What Will the Medication Look Like?	Common Examples
Over-the-counter (nonprescription): Medication that you can get without an order (prescription) from a licensed authorized prescriber. It can be a generic or brand name medication.	Over-the-counter medications all look different. They do not have a pharmacy label with instructions for use that are specific to the child. Food/ nutrition products, lotion, lip balm, medicated bandages, topical ointments, sunscreen, insect repellent and Vaseline® are not considered medication unless they are administered by prescription.	Tylenol®, Dimetapp®, Motrin®, ibuprofen, Benadryl®, homeopathic treatments
Prescription: Medication that needs an order (prescription) from a licensed authorized prescriber to be obtained from the pharmacy. Prescription medication treats a specific condition and can be a generic or brand name.	All prescription medication comes in a container/bottle with a pharmacy label. The pharmacy label will be for a specific child and includes instructions for how to give the medication.	amoxicillin, albuterol, EpiPen®, Ritalin®, Cortisporin Otic®, Augmentin® etc.
Controlled Substances: Medication designated as having a high potential for misuse, which are regulated by the federal government.	Controlled substances may have a label on the medication container that tells you it is a controlled substance, or they may have the letter C at the beginning of the prescription number.	Ritalin® and Focalin®
Brand name: The name given to the medication by the pharmaceutical company that created it.	The medication name on the label will have the symbol ® after it to identify it as a registered trademark.	Tylenol®, Motrin®, Cipro®, Benadryl®, Ventolin®
Generic name: The chemical name of the active ingredient in the medication	The medication name on the label will be listed as the "active ingredient."	amoxicillin, acetaminophen, ibuprofen, diphenhydramine, albuterol

Generic and Brand Name Medications

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 ingredients (acetaminophen), but may be slightly different from one another because of the inactive ingredients. **See diagram**.



Special Authorizations and Individual Health Care Plan

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

Child's name:	**Child's date of birth:**
Name of the child's health care provider:	☐ **Physician** ☐ **Physician Assistant** ☐ **Nurse Practitioner**

Describe the health care needs of this child and the plan of care as identified by the parent and the child's health care provider.

Identify the program staff who will provide care to this child:

Name	Credentials or Professional License Information*

Describe any additional training, procedures or competencies the staff identified will need to carry out this plan, as identified by the child's parent and/or the child's health care provider. In addition, describe how this additional training will be achieved including who will provide this training.

Signature of Authorized Program Representative:

I understand that it is my responsibility to follow the above plan and all health and infection control 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 those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications 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 address:	Facility Telephone Number:
Authorized child care provider's name (please print)		Date:
Authorized child care provider's signature:		

Signature of Parent or Guardian:

	Date:

Signature of Health Care Provider:

	Date:

Signature of Person Providing Training (if applicable):

	Date:

Required Permissions to Give Medications

The permissions and instructions needed to give a specific medication to a specific child are provided on the Medication Consent Form. Although it is best practice to use the MAT Medication Consent Form, other forms can be used, as long as all the information required by Licensing regulations is included.

- It is recommended as best practice, but not required by Licensing regulations, that parent(s) and health care providers renew the Medication Consent Form at least **once every twelve months**
- Faxed Medication Consent Forms are acceptable.
- The Consent Form instructions for administration must be consistent with any directions for use noted on the medication container, including precautions related to age and special health conditions. **If the instructions are not consistent, *written* instructions from the child's health care provider are required.**
- ***** NOTE: All short-term (10 working days or less) permissions must be renewed or discontinued after ten working days.** ***
- ***** NOTE: ALL Nebulizer and Epi-Pen permissions, even short-term ones, must be signed by the health care provider.*****

PERMISSION REQUIREMENTS
SHORT-TERM MEDICATION ADMINISTRATION

The following table indicates the permission needed to administer a medication to any child in your care for **ten working days or less**.

Medication Type	Medication Route	Type of Permission Needed (written)	
		Parent Permission	Health Care Provider Instructions
Over-the-counter*	Topical	Written	*None needed*
	Oral	Written	*None needed*
	Inhaled/Nasal	Written	*None needed*
	Patches	Written	*None needed*
	Eye	Written	*None needed*
	Ear	Written	*None needed*
Prescription	Topical	Written	*None needed*
	Oral	Written	*None needed*
	Inhaled/Nasal	Written	*None needed*
	Patches	Written	*None needed*
	Eye	Written	*None needed*
	Ear	Written	*None needed*
	Nebulizer	Written	Written
	Epinephrine auto-injector	Written	Written

PERMISSION REQUIREMENTS
LONG-TERM MEDICATION ADMINISTRATION

- ***** NOTE – ALL long-term (more than 10 working day) permissions MUST be signed by the parent AND healthcare provider, EXCEPT for over-the-counter topicals**

The following table indicates the permissions/instructions needed to administer a long-term medication to any child in your care. Long-term medication is defined as any medication that is authorized by the parent and/or health care provider to be administered or possibly administered for **more than ten working days**.			
Medication Type	**Medication Route**	**Type of Permission Needed (written)**	
		Parent Permission	**Health Care Provider Instructions**
Over-the-counter*	**Topical**	**Written**	***None needed***
	Oral	**Written**	**Written**
	Inhaled/Nasal	**Written**	**Written**
	Patches	**Written**	**Written**
	Eye	**Written**	**Written**
	Ear	**Written**	**Written**
Prescription	**Topical**	**Written**	**Written**
	Oral	**Written**	**Written**
	Inhaled/Nasal	**Written**	**Written**
	Patches	**Written**	**Written**
	Eye	**Written**	**Written**
	Ear	**Written**	**Written**
	Nebulizer	**Written**	**Written**
	Epinephrine auto-injector	**Written**	**Written**

*Over-the-counter diaper cream, sunscreen, insect repellant, lotion, lip balm and Vaseline are not considered medications, and do not require a Consent Form for either short-term or long-term administration.

Independent Medication Administration

If a child carries his own medication, decides when a dose is needed and takes the dose without supervision, this is considered Independent Medication Administration.

- In some cases, it is appropriate for children with **diabetes** to provide independent medication administration for this condition. The MAT Diabetes course provides complete information on this and other MAT best practices for caring for children with diabetes.
- Children can independently self-administer an **emergency rescue medication** such as an inhaler or EpiPen **ONLY if the following criteria are met:**
  - The child is at least 9 years old.
  - The physician, parent and child day program director have given written permission to the child, based on their judgment that the child is responsible enough to correctly store and self-administer the mediation, using Handout 4.2 S, Permission to Self-Carry and Self-Administer Emergency Rescue Medications.
  - The child day program director must additionally consider whether this child can safely self-carry and self-administer this medication in this program environment, and can withhold permission if he or she feels for any reason that this cannot be safely done in this environment, regardless of the capabilities of the child.
  - The parent and the child acknowledge in writing using Handout 4.2 S that this permission to self-administer will be revoked if the child does not consistently, correctly and responsibly perform his or her medication storage and self-administration tasks.
- **All questions about whether a child can be permitted to independently self-administer medication should be referred to your Licensing inspector or representative.**

Your program should also have a Special Authorizations and Individual Health Care Plan (Handout 3.7) for each child who will independently administer his medication. The child's plan should:

- 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
- list any additional training or competencies staff approved to give medication may need to care for the child and who will provide this training

Permission to Self-Carry and Self-Administer Emergency Rescue Medications

To be completed by health care provider and parent/guardian, IN ADDITION to Medication Consent Form(s)

Child's Name and DOB: _____

Child Day Program or Private School: _____

Child's physician or other relevant licensed health care provider confirms that the child has a diagnosis of _____, is independent and can safely perform the emergency rescue self-care specified below, and has approval to self-administer this care:

- Epinephrine auto-injector: _____
- Metered Dose Inhaler: _____

The child understands that he/she is to promptly report to a MAT certified staff member, qualified health care professional or other responsible adult as soon as possible when symptoms of requiring the above self-care appear.

Physician/health care provider agrees to prepare a written Individual Health Care Plan or Asthma/Allergy Care Plan in consultation with the child's parents and appropriate personnel.

Specific duration of order:	Physician/Health Care Provider Signature: Provider Printed Name:	Office Phone: Office Fax: Date:

Parent/Guardian Statement:

My child has been instructed in and understands his/her emergency rescue self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the child day program director/administrator/family day home with a copy of my child's Care Plan signed by his/her physician.

I hereby give permission for the child day program to administer the medications as prescribed in the Care Plan, if indicated (i.e., child requests assistance or becomes unable to perform self-care).

I will not hold the child day program or any of its employees liable for any negative outcomes resulting from the self-administration of the emergency rescue care specified above by my child.

I understand that the child day program director/administrator/family day home, after consultation with the parent/guardian, may impose reasonable limitations or restrictions upon my child's possession and self-administration of the emergency rescue medication specified above, relative to his/her age and maturity or other relevant considerations.

I understand that the child day program may revoke permission to possess and self-administer said emergency rescue medication at any point if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

_____ _____

Parent/Guardian Signature **Date** **Child Signature** **Date**

_____

Program Administrator **Date**

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 accept the medication.

Checklist for Accepting Medication	✓ Check
1. Signed written permission and/or instructions received from the parent/guardian.	
2. Instructions written on the medication label and package match the instructions on the **Consent Form**. ❑ Review **the Consent Form**, making sure all instructions are correct and understood. • Why the child is taking the medication • The Five Rights • What potential side effects you should be looking for – it is strongly recommended that potential side effects be written out, identified as mild or serious, and action to be taken for serious side effects included, on the Consent Form itself • If the medication is to be given for ten or fewer working days, or on a long-term basis • Any special storage requirements are indicated on the medication label or in the health care provider instructions	
3. Medication is in the original container (child resistant whenever possible) and labeled with the child's full name. • Prescription medication has a readable pharmacy label attached to the container. If needed, the parent also provides any special tools, such as a dosing spoon or oral syringe, with the child's first and last names written on it.	
4. Expiration date is on medication package and the medication has not expired.	
5. You have written instructions from the health care provider, if required per Handout 4.1. • The instructions are complete, understandable and signed by the health care provider, if the medication is to be given longer than 10 working days, if the package states "consult physician", or if there is	

a discrepancy between parents' instructions & label/packaging instructions. • If the medication is to be given a certain number of times per day, and the health care provider did not write a specific time, such as 1:00PM, in Item 7, make sure the parent writes the specific time to give the medication.	
6. If the **Special Instructions** on the Consent Form or the medication label impact when the medication should be given, such as "with a meal" or "on an empty stomach", and the **dose is scheduled for a time when these instructions can't be followed**, work with the parent to have her **change the scheduled time of the dose to a time when you can follow the instructions**.	
7. Fill out the child care or school Program section on the **Medication Consent Form** and tell the parent you are agreeing to give the medication.	
7. Put the medication in the medication storage area or refrigerator. Ensure that this is the same storage area included in your medication administration policy/procedure.	
8. Create a **Log of Medication Administration** for the child's medication.	
9. File the **Medication Consent Form**, any package inserts or pharmacy printouts and the **Log of Medication Administration** together in a place where you will be able to review the forms each day.	

Medication Storage and Disposal

Medication Storage

When deciding where to keep medication, follow these guidelines:

For general medication

- Lock in a clean and secure place that children cannot get to (inaccessible).
- Keep in a cool, dry and dark place, unless the directions state something else.
- Keep in the original labeled bottle or container
- Keep in a child resistant container whenever possible
- Label with the child's first and last name if it is an over-the-counter medication
- Keep refrigerated if instructed
- Check periodically for expiration
- Notify parents when a medication supply is low. For long-term medication you may want to keep at least a one week supply available to avoid running out.

Emergency medication

- Keep in an area near the child where you get it quickly, such as
  - in your emergency bag; or
  - in a pack that you wear.

Your medication administration policy/procedure should include the place(s) 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 medication administration policy/procedure.

Refrigerated medication

- Store in a refrigerator that is inaccessible to children.
- Store separately from food and keep in a leak proof container. A leak proof 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 inaccessible to children.
- Keep the refrigerator at the temperature between 36 - 40° 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 within 14 days, 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 America Pharmaceutical Association recommends first crushing or dissolving the medication in water.
- Place the material in a leak proof container, such as an empty can or a sealed plastic bag.
- Throw the container in the trash.
- NOTE: Medication administration items, such as expired epinephrine auto-injectors, empty nebulizer vials, and used insulin syringes, must be disposed of in a closed impenetrable container.

Medication Label Information and Medication Tools

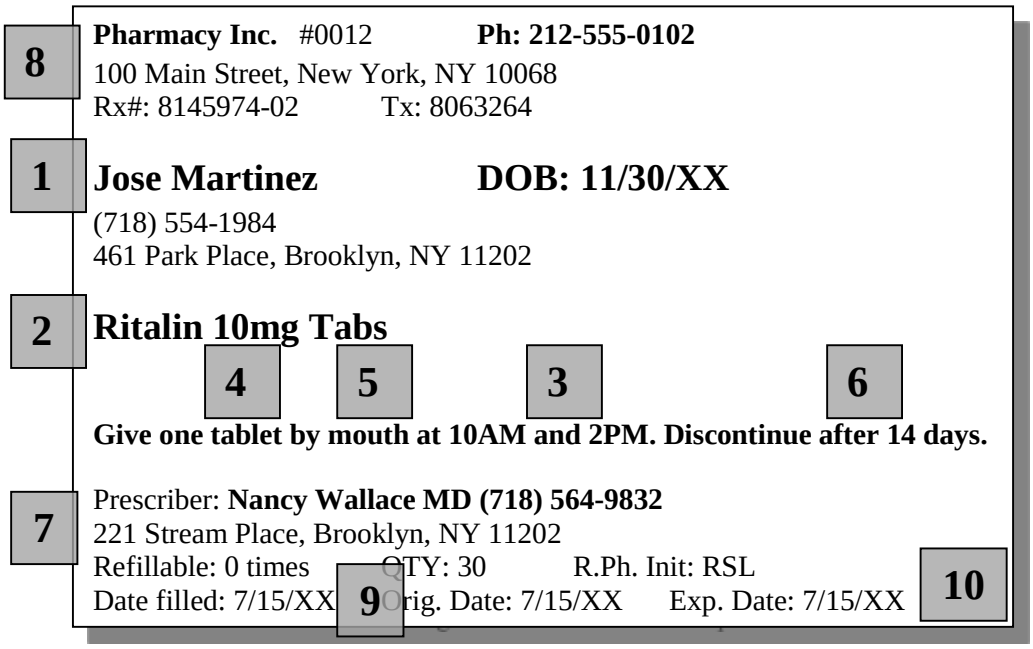
Over-the-Counter Medication Label Requirements

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

Prescription Medication Label Information

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

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



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.

Administration Tools

Administration tools, such as dosing spoons, oral medication syringes, pill crushers and medicine cups should be provided by the parent. All medication administration tools including pill crushers are child specific and cannot be shared with a different child. All tools must be labeled with the child's first and last names. The child care provider may keep an emergency supply of disposable, single use measuring devices on hand.

COMMON MEDICAL ABBREVIATIONS

Abbreviation	Meaning
ā	before
ac	before meals
bid, BID	twice a day
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	microgram
mg	milligram
ml	milliliter
NKA	no known allergies
NKDA	no known documented allergies
OD	right eye
OS	left eye
OU	each eye
oz	ounce
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
qod, QOD	every other day
s	without
i	one
ii	Two
iii	Three
tbsp., T	Tablespoon
tid, TID	three times a day
tsp, t	Teaspoon

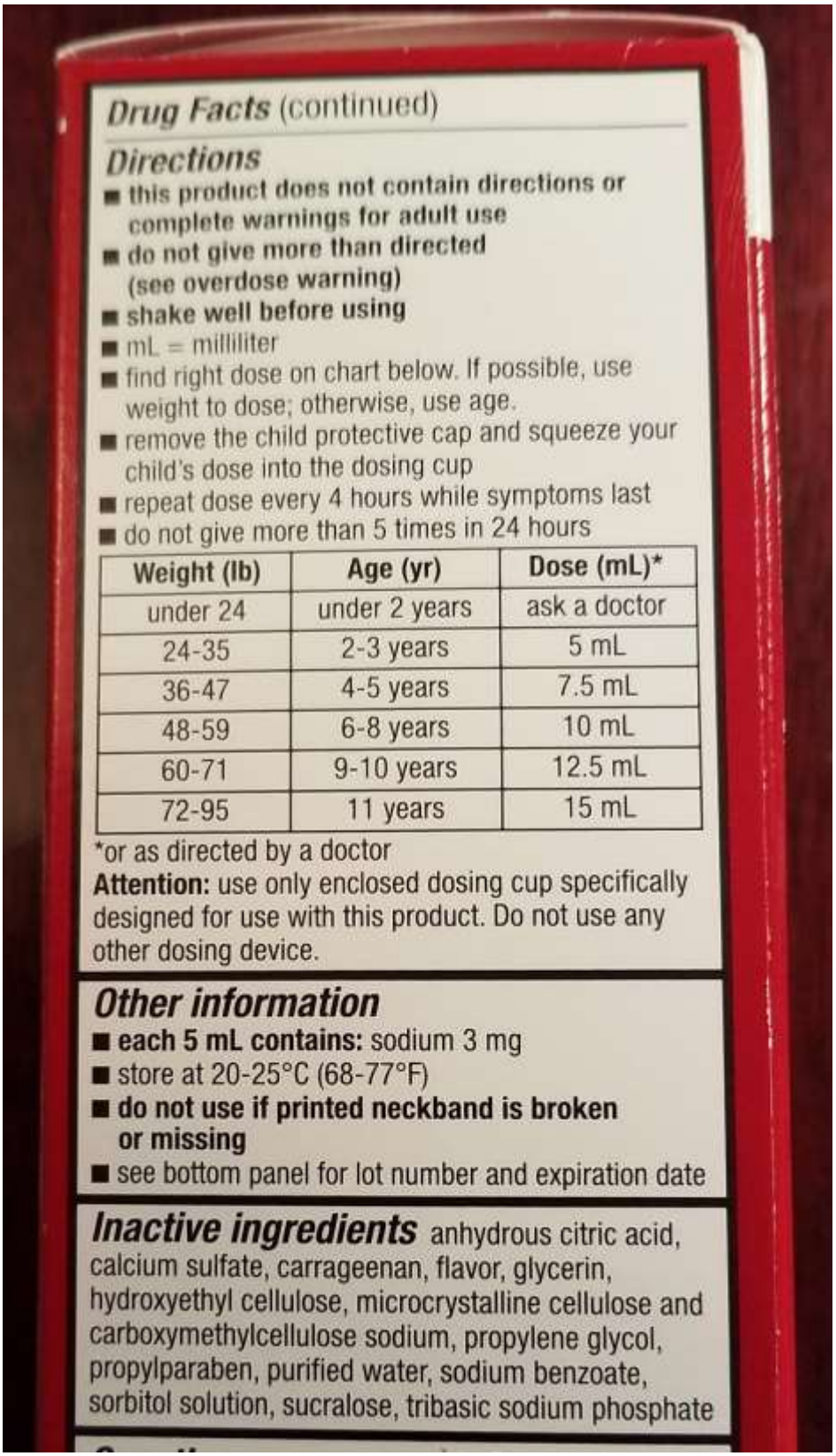
Exercise: Accepting Medication

***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 gives you the Children's Acetaminophen with Carly's name on it and a signed Consent Form *(see next page for Consent Form).*

1. **Do you have the permissions and instructions from Carly's health care provider that are required for you to administer the medication? If not, what are the reasons you cannot give this dose?**

2. **If there was a problem with the permissions or instructions, what can you and the parent do to correct the problem?**



Drug Facts (continued)

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 below. If possible, use weight to dose; otherwise, use age.
- remove the child protective cap and squeeze your child's dose into the dosing cup
- repeat dose every 4 hours while symptoms last
- do not give more than 5 times in 24 hours

Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL
36-47	4-5 years	7.5 mL
48-59	6-8 years	10 mL
60-71	9-10 years	12.5 mL
72-95	11 years	15 mL

*or as directed by a doctor

Attention: use only enclosed dosing cup specifically designed for use with this product. Do not use any other dosing device.

Other information

- **each 5 mL contains:** sodium 3 mg
- store at 20-25°C (68-77°F)
- **do not use if printed neckband is broken or missing**
- see bottom panel for lot number and expiration date

Inactive ingredients anhydrous citric acid, calcium sulfate, carrageenan, flavor, glycerin, hydroxyethyl cellulose, microcrystalline cellulose and carboxymethylcellulose sodium, propylene glycol, propylparaben, purified water, sodium benzoate, sorbitol solution, sucralose, tribasic sodium phosphate

Exercise: Accepting Medication

Answer Key

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 gives you the Children's Acetaminophen with Carly's name on it and a signed Consent Form *(see next page for Consent Form).*

1. **Do you have the permissions and instructions from Carly's health care provider that are required for you to administer the medication? If not, what are the reasons you cannot give this dose?**

   To determine the whether you have the required permissions, you check Handout 4.1 – Required Permissions to Give Medications.

   The first problem is that the Consent Form is for Tylenol, a branded medication, and the parent has given you generic acetaminophen, so you cannot give the medication.

   *The second problem is that the child is 10 months old, the Consent Form is not signed by a physician, but the package instructions say to consult physician if the child is under 2 years old. So in a case like this, the physician's signature is required on the Consent Form**. So you don't have the required permissions.***

   *NOTE - Participants might say that you can't give the medication because on the Consent Form, the medication is identified as **"Children's Tylenol" without a strength noted. This is not a problem,** because for branded over-the-counter medications, if the branded name includes the age (such as "Infant's", "Children's" or "Adult's"), then this is the strength.*

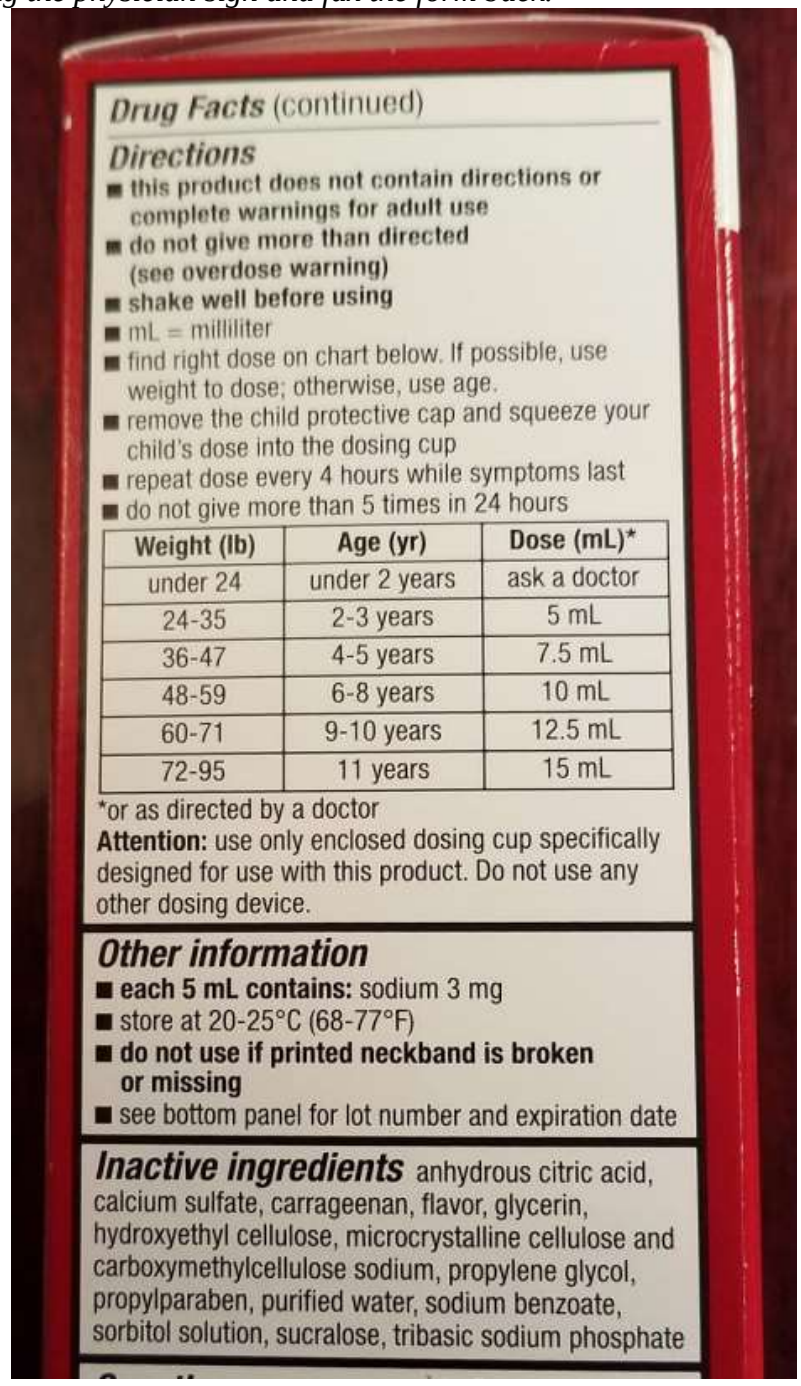
2. **If there was a problem with the permissions or instructions, what can you and the parent do to correct the problem?**

   ***To correct the medication name issue on the Consent Form**, you need the parent to either add or change the medication name to acetaminophen.*

   And because generic medications can come in varying strengths and are not always as consistently labelled as branded medications, for generic medications, you need to have the parent add the strength on the Consent Form – in this case, the package says it's "160 mg / 5 mL". So the Medication and Strength should read "acetaminophen 160 mg / 5 mL" on the Consent Form.

*REMIND the participants that **prescription medications ALWAYS come with the strength noted on the pharmacy label** – so they need to make sure the name and strength of the medication are written the same way on the Consent Form.*

***Adding the physician's signature** - You also need to have the parent get the physician's signature on the Consent Form, which can be done by faxing the form to the physician and having the physician sign and fax the form back.*



Drug Facts (continued)

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 below. If possible, use weight to dose; otherwise, use age.
- remove the child protective cap and squeeze your child's dose into the dosing cup
- repeat dose every 4 hours while symptoms last
- do not give more than 5 times in 24 hours

Weight (lb)	Age (yr)	Dose (mL)*
under 24	under 2 years	ask a doctor
24-35	2-3 years	5 mL
36-47	4-5 years	7.5 mL
48-59	6-8 years	10 mL
60-71	9-10 years	12.5 mL
72-95	11 years	15 mL

*or as directed by a doctor

Attention: use only enclosed dosing cup specifically designed for use with this product. Do not use any other dosing device.

Other information

- **each 5 mL contains:** sodium 3 mg
- store at 20-25°C (68-77°F)
- **do not use if printed neckband is broken or missing**
- see bottom panel for lot number and expiration date

Inactive ingredients anhydrous citric acid, calcium sulfate, carrageenan, flavor, glycerin, hydroxyethyl cellulose, microcrystalline cellulose and carboxymethylcellulose sodium, propylene glycol, propylparaben, purified water, sodium benzoate, sorbitol solution, sucralose, tribasic sodium phosphate

Medication Consent Form — Handout 4.7

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Carly McMahon	**June 1, 20xx**	**none**

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Children's Tylenol	**1 tsp**	**Oral**

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

Parent's signature approving Specific Time(s)_____

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters). **Teething pain**

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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): **teething**

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
X No □Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 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 12 months from the date authorized or this order will not be valid): **3 days**
10/21/CY	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**:

18. **Licensed authorized prescriber's signature**:

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

Medication Consent Form — Handout 4.7

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Carly McMahon** (child's name) .	
20. Parent or legal guardian's name (please print): **Megan McMahon**	21. Date authorized: **10/21/CY**
22. Parent or legal guardian's signature: ***Megan McMahon***	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:	29. Facility Phone Number:
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print):	31. Date received from parent:
32. Authorized child care provider's signature:	

Case Study 2: Khalil Khan is a six-year old in your program. He has been home with a throat infection for five days, taking amoxicillin. His fever is gone now and his mother has brought him to your program. She has brought his amoxicillin and the Consent Form on the next page, and asks you to give him his remaining 5 days of this medication. **Do you have the necessary instructions and permissions to do this?**

Case Study 2: Khalil Khan is a six-year old in your program. He has been home with a throat infection for five days, taking amoxicillin. His fever is gone now and his mother has brought him to your program. She has brought his amoxicillin and the Consent Form on the next page, and asks you to give him his remaining 5 days of this medication. **Do you have the necessary instructions and permissions to do this?**

Yes, you can give this medication. This is a prescription medication to be given for 5 days, so it is a short-term permission. Short-term permissions don't require a physician signature unless they are for nebulizer or epinephrine auto-injector.

Medication Consent Form

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Khalil Khan	**June 1, 20xx**	**none**

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Amoxicillin 250mg/5ml	**1 tsp**	**Oral**

7A. **FREQUENCY**: **3 times per day** **Specific TIME(s)** (e.g. 1p.m.): ***2 pm***

Parent's signature approving Specific Time(s) ***Sally Khan***

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

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

X Contact parent □ Contact prescriber at phone number provided below

□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) **Give on an empty stomach**

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

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

X No □Yes If you checked yes, complete #25 and #27 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?

X No □ Yes If you checked yes, complete #26 and #27 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 12 months from the date authorized or this order will not be valid): **5 days**
10/2/CY	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**:

18. **Licensed authorized prescriber's signature**:

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

This is a double-sided form

Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Khalil Khan** (child's name) .	
20. Parent or legal guardian's name (please print): **Sally Khan**	21. Date authorized: 10/1/CY
22. Parent or legal guardian's signature: *Sally Khan*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: 804-555-2784
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Anne Barber**	31. Date received from parent: 10/2/CY
32. Authorized child care provider's signature: *Anne Barber*	

This is a double-sided form

***Case Study 3*:** Simon Johnson is a six year old child in your program. He has an ear infection and has been prescribed amoxicillin. His mother has just given you his bottle of amoxicillin and the Consent Form on the next page.

1. **Do you have the required instructions and permissions to accept this medication? If not, what are the reasons you cannot accept this medication?**

2. **If the medication cannot be accepted with the instructions and permissions you have, what can be done to correct the problem?**

***Case Study 3*:** Simon Johnson is a six year old child in your program. He has an ear infection and has been prescribed amoxicillin. His mother has just given you his bottle of amoxicillin and the Consent Form on the next page.

1. **Do you have the required instructions and permissions to accept this medication? If not, what are the reasons you cannot accept this medication?** *Although you have the correct permissions to give this medication, the instructions say "three times a day", and you have not been given a specific time for the dose, so that the dose you give is coordinated with times when the parents give doses at home. You need to resolve this before you can accept the medication.*

2. **If the medication cannot be accepted with the instructions and permissions you have, what can be done to correct the problem?** *When the parent gives you the consent form, ask the parent what specific time they would like you to give the dose, and have the parent write that time on the Consent Form and sign it. (Trainers, see the SECOND Simon Johnson Consent Form attached for an example of this information entered on the Consent Form)*

MAT Medication Consent Form — Handout 4.7

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Simon Johnson	**June 1, 20xx**	**none**

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Amoxicillin 250mg/5ml	**1 tsp**	**Oral**

7A. **FREQUENCY**: **3 times per day to administer** **Specific TIME(s)** (e.g. 1p.m.): _____

*Parent's signature approving Specific Time(s)*_____

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

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

X Contact parent □ Contact prescriber at phone number provided below

□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) **Give on an empty stomach**

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

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

X No □Yes If you checked yes, complete #25 and #27 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?

X No □ Yes If you checked yes, complete #26 and #27 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 12 months from the date authorized or this order will not be valid): **14 days**
10/21/CY	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**: 804-564-9832
Nancy Wallace, MD	

18. **Licensed authorized prescriber's signature**: Nancy Wallace, MD

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

This is a double-sided form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Simon Johnson** (child's name) .	
20. Parent or legal guardian's name (please print): **Jennifer Johnson**	21. Date authorized: 10/1/CY
22. Parent or legal guardian's signature: *Jennifer Johnson*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: 804-555-2784
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Anne Barber**	31. Date received from parent: 10/2/CY
32. Authorized child care provider's signature: *Anne Barber*	

This is a double-sided form

Medication Consent Form — Handout 4.7

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Simon Johnson	**June 1, 20xx**	**none**

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Amoxicillin 250mg/5ml	**1 tsp**	**Oral**

7A. **FREQUENCY**: **3 times per day to administer** **Specific TIME(s)** (e.g. 1p.m.): ***2 pm***

Parent's signature approving Specific Time(s) ***Sally Johnson***

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) **Give on an empty stomach**

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

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
X No □Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 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 12 months from the date authorized or this order will not be valid): **14 days**
10/21/CY	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**: 804-564-9832
Nancy Wallace, MD	

18. **Licensed authorized prescriber's signature**: Nancy Wallace, MD

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

This is a double-sided form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Simon Johnson** (child's name) .	
20. Parent or legal guardian's name (please print): **Jennifer Johnson**	21. Date authorized: 10/1/CY
22. Parent or legal guardian's signature: *Jennifer Johnson*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: 804-555-2784
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Anne Barber**	31. Date received from parent: 10/2/CY
32. Authorized child care provider's signature: *Anne Barber*	

This is a double-sided form

***Case Study 4*:** Joshua Liebowitz is a four-year-old child in your program. You have been giving him a medication called carbamazepine every day at 12:00pm 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 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 the Item 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?**

***Case Study 4*:** Joshua Liebowitz is a four-year-old child in your program. You have been giving him a medication called carbamazepine every day at 12:00pm 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 **.**

   The label on Joshua's carbamazepine bottle does not match the dose written on the consent form.

   However, Item 13 has been checked yes by the health care provider, telling you that this is a change in medication instructions.

   And Items 26 (indicating when the pharmacy is expected to refill this prescription under these new instructions) and 27 (physician's signature to Item 26) have also been completed.

   This tells you that the health care provider has changed the medication instructions. In this case, the dosage of the medication has been lowered.

   Since there is still medication remaining in the bottle, the pharmacy won't refill the medication until medication from the previous prescription is completely used.

   Therefore, you must follow the instructions on the NEW Medication Consent Form (which won't match the pharmacy label) until the new prescription has been filled. Then the pharmacy label and the Medication Consent Form will match.

2. You see the Item 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, as explained above, the physician has provided revised dosage instructions on this new written consent form and has provided a date by which the pharmacy will refill the prescription. So you can continue to administer the current bottle of medication until the date given by the physician in Item 26 even though the medication label does not match the new written health care provider instructions.

MAT Medication Consent Form

Handout 4.7

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Josh Liebowitz	***2/6/XXXX (4 years old)***	***None***

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Carbamazepine suspension (100mg/5ml)	***1 tsp***	***oral***

7A. **FREQUENCY**: **Specific TIME(s)** (e.g. 1p.m.): ____12 noon_____

to administer _____ *Parent's signature approving Specific Time(s)* _____

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters)

8. **Possible side effects**: X See package insert (parent must supply) *AND/OR* additional side effects:

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

X Contact parent □ Contact prescriber at phone number provided below

□ Other (describe):

10. **Special instructions**: X See package insert (parent must supply) *AND/OR* 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): ***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 require health and related services of a type or amount beyond that required by children generally?

□ No X Yes If you checked yes, complete #25-#27 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 X Yes If you checked yes, complete #26-#27 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 12 months from the date authorized or this order will not be valid):
10/13/XXXX	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**:
Dr. Gary Marchione	***(914) 555-1998***

18. **Licensed authorized prescriber's signature**: X *Gary Marchione*

Required for Long-Term medications, PRN "as needed" medications and when dosage directions state "consult a physician".

MAT Medication Consent Form

Handout 4.7

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to ***Josh Liebowitz*** child's name) .	
20. Parent or legal guardian's name (please print): ***Gabriel Liebowitz***	21. Date authorized: ***10/14/XXXX***
22. Parent or legal guardian's signature: x *Gabriel Liebowitz*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
See Individual Health Care Plan
26. 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: 11/13/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.
27. Licensed Authorized Prescriber's Signature: x x *Gary Marchione*

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:	29. Facility Phone Number:
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print):	31. Date received from parent:
32. Authorized child care provider's signature:	

Guidelines for 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
☺ Properly position the child.
☺ Rock the baby before and after giving any medication.
☺ Give medicine prior to a feeding, unless the healthcare provider's instructions specifically state to not given before a feeding.
☺ Allow child to rest between "pulses" of medicine when using an oral syringe.

DON'T:

⊗ Add medication to a bottle of formula or breast milk
⊗ Pinch a baby's nose to get him to open his mouth
⊗ Shake an uncooperative child

Toddlers

☺ Approach the child expecting cooperation.
☺ 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 with the child giving medicine to a doll or stuffed animal.
- ☺ Plan for time before and after giving the medication to soothe the child.
- ☺ Thank the child for cooperation.
- ☺ Ask parents what techniques they use successfully.

DON'T:

- ⊗ Ask the child if he wants to take his medicine
- ⊗ Mix medicine in a large amount of food

Preschoolers

- ☺ Approach the child expecting cooperation.
- ☺ Prepare the child to take medication. Use age appropriate language to explain to the child that what you are doing will help him feel better and gently tell him what you need him to do.
- ☺ 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 you take your medication?"
- ☺ Thank the child for cooperation.

DON'T:

- ⊗ Mix medicine in a large amount of food
- ⊗ Refer to the medication as "candy"
- ⊗ Threaten to give medication as punishment

School Age Children

- ☺ Prepare the child to take the medication.
- ☺ If taking the medication is stressful for the child, help her 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.
- ☺ Approach the child expecting cooperation.
- ☺ Thank the child for cooperation

DON'T:

- ⊗ Crush pills or open capsules without instructions from the health care provider
- ⊗ Threaten to give medication as punishment
- ⊗ Call medication "candy"

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 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.
  - Consult your program's policies and procedures and, if applicable, the child's health care plan for any additional actions.

- **If the child spits up (or vomits) immediately or soon after getting oral medication:**
  - Do not administer the dose again.
  - Notify the child's parent as soon as possible.
  - 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 of the Medication Consent Form with the new discontinue date.
  - Give the medication back to the parent.

Giving Medication Safely

Always have any supplies you may need, such as gloves, tissues, dosing tools, etc., available at the medication administration area *before* starting the medication administration process. Here are the steps to follow to give medication safely:

1. Preparing to give the medication:

- ❑ **Check the child's Log of Medication Administration and Consent Form** to make sure the child hasn't been given this dose already, and, if it's an "as needed" medication, that this dose will not be given too soon after the last dose.
- ❑ **Get the correct child** and bring the child to the medication administration area.
- ❑ **Wash your hands and the child's hands**.
- ❑ Bring the child's Consent Form to where you store the medication. **Select the correct medication. Before you leave the medication storage area**, match the **Five Rights** on the medication label to the child's Consent Form.

  □ child's full name □ medication and strength □ dose □ route □ time

- ❑ Once you take the medication from the storage area, you must never leave it unattended.
- ❑ Check the Consent Form and medication package to see if there are any **special instructions for giving the medication**, such as shaking it well, giving it with food or on an empty stomach, to be prepared to follow these instructions when giving the medication.
- ❑ Check the **expiration date** on the medication to make sure it has not expired.

2. Giving the medication:

- ❑ Give the medication by following the appropriate **Procedure Guide** (Handouts 9.1 to 9.7) for the correct steps to administer medication by each route, following the instructions on the medication package and the Consent Form.

3. Documenting the dose:

- ❑ **Immediately after giving the dose, match the Five Rights** the third and final time.

  □ child's full name □ medication and strength □ dose □ route □ time

- ❑ Then immediately **document the dose on the child's Log of Medication Administration.** Document the dose **BEFORE** you return the medication to the storage area and **BEFORE** you return the child to the group.

  - □ For "**as needed" medications**, record the specific symptoms that prompted you to give the dose, and the time when you notified the parent of the dose.
  - □ For **missed doses**, document them and record the reason why they were missed.

- ❑ **Return the medication to the storage area** immediately after you document the dose and **BEFORE** returning the child to the group.

- ❑ **Wash your hands and the child's hands** again.

- ❑ **Return the child** to the group.

- ❑ If the child has **side effects** from the dose, document the side effect(s), what actions you took if the side effect was serious or adverse, and the time when you notified the parent.

How to Document a Dose

You must keep a record of all the medication given at your program. A Log of Medication Administration is a useful tool in documenting the administration of medication and communicating to other providers in the program that the medication was given. 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 mistakenly receiving two doses.

Here is how to document a dose:

- **Document all medication doses** you administer.
- Always write **in ink** and write clearly so others can read your writing.
- Use **one *Log of Medication Administration* for each medication** the child is taking.
- Document each dose **immediately after the child takes it and you do the third match of the Five Rights.**
- Document the *actual* **date and time** you gave the medication (include **a.m. or p.m.**).
- Document the *actual* **dose** you gave.
- Document the **route** you *actually* gave the medication by, using the **same wording** that was used on the Consent Form. For example, if the Consent Form says "Oral", if you gave the medication by the Oral route, write "Oral", not "by mouth". Add the **side of the body** if the medication was given in the eye, ear or nostril, or the **specific location on the body** for topical medications or epinephrine auto-injections.
- If you gave an **"as needed"** medication, document the **specific symptoms** that caused you to give the medication, and the **time** the parent/guardian was notified of the dose, including a.m. or p.m.
- **Sign** the entry and print your name.
- After waiting the correct amount of time for side effects to appear, document any **side effects** the child had, the actions you took if the side effect was serious or adverse, and the time the parent was notified, including a.m. or p.m.
- If a dose that should have been given was **not given**, document this as a missed dose and document the reason why the dose was missed.
- **If you make an error** while documenting a dose, cross out the incorrect information, write "error" with your initials next to it, then write the correct information.

  e.g., Dose: ~~Two drops~~ *Error MW*

  Dose: One Drop

Field Trips

If any children will need medication while off the program site, you will need:

- A MAT certified provider on the field trip if any of the children on the trip need medication
- The medication in the original pharmacy container
- The medication kept in a locked place or locked container
- The medication packed separately from food and other supplies.
- If the medication requires refrigeration, a way to keep it at a temperature between 36-40^{o}F
- Any administration tools or special equipment needed to give the medication
- The child's original **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
- To provide confidentiality while administering medication off the program site

For children not going off-site:

If any children will need medication while others are off the program site, you need:

- A MAT certified provider available to administer the medication; and
- The **Medication Consent Form** and **Log of Medication Administration** available for any child left at the program.

Medication Errors

A medication error is a mistake that is made anytime during the process of giving medication.

Medication errors include:

- Forgetting to give a dose
- Giving an extra dose
- Giving the wrong medication
- Giving the medication at the wrong time
  (*This includes giving medication more than 30 minutes before or more than 30 minutes after the schedules time OR giving medication for symptoms that are not specified by the health care provider OR giving a dose too soon after the last dose.*)
- 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 the required permissions or with expired permissions

Reporting a Medication Error

- 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.
- Provide for the immediate needs of the child as directed by the child's parent and health care provider.
- Complete the Medication Error Report Form.

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

Medication Error Report Form

- You can use this form or you can create your own master form using this as a guide.
- All areas of this form must be completed.
- The child's parent must be notified immediately of all medication errors.
- Provider should encourage parents to notify the child's health care provider of any medication administration errors.
- If more than one child is involved in the error, an error form must be completed for each child.

Provider/Facility name:	Facility address:	Facility telephone number:
Child's name:		Child's date of birth:
Date of medication error:		

What type of medication error occurred:

- ☐ Incorrect child
- ☐ Incorrect medication
- ☐ Incorrect time *(gave more than 30 minutes before or 30 minutes after time authorized)*
- ☐ Incorrect dose
- ☐ Incorrect route
- ☐ Gave an expired medication
- ☐ Forgot to give medication
- ☐ Consent expired
- ☐ Other _____

Complete this section for all errors using the information provided on the child's approved consent form *(except for incorrect child)*		
Name of medication authorized:	Amount/dosage authorized:	Route of adminstration authorized:
Frequency to be administered or signs and symptoms that necessitate the need for the medication as authorized on the consent: _____		

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

Action Taken:

Parent/Guardian notified (required immediately) □ Yes □ No	Date notified (month/day/year):	Person notified:
Encouraged parent to notify health care provider □ Yes □ No	Date advised (month/day/year):	Person advised:
Other persons notified (ex: child care health consultant): □ Yes □ No	Date notified (month/day/year):	Person(s) notified:

Describe Corrective Action Taken (indicate that an investigation will be done):

Name of person completing this form: *(please print)*	Date form completed:
Signature of person completing this form:	

Exercise: Giving Medication Safely

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

Case Study* 1:** You are a provider taking the MAT course. You have been given the following skill demonstration scenario to practice in pairs: ***"Simon Johnson is a is a ten-month old child in your program. His mother has dropped off a bottle of amoxicillin and a Consent Form for him. It is 2pm. Using the Consent Form, give his medication." *(the Consent Form is on the next sheet).* Your partner is demonstrating, and you are grading her. She reaches the "Five Rights" step in the medication administration process, and does the following:

- *Reads the medication information on the label and the Consent Form, saying out loud "Amoxicillin, Amoxicillin"*
- *Reads the dose information on the label and the Consent Form, saying out loud "1 teaspoon, 1 teaspoon"*
- *Reads the route information on the label and the Consent Form, saying out loud "Oral, by mouth, which is the same thing"*
- *Reads the time information on the label and the Consent Form, saying out loud" 2pm, three times a day"*
- *Reads the child information on the label and the Consent Form, saying out loud "Simon, Simon"*

CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED

Pharmacy Inc. #0012 **Ph: 804-555-0102**
100 Main Street, Richmond, VA 23235
Rx#: 8145973-02 Tx: 8063264
Simon Johnson **DOB: 06/01/xx**
(804) 554-1984
461 Park Place, Richmond, VA 23235
AMOXICILLIN 250MG/5mL

Give one teaspoon (5cc) by mouth 3 times a day for 14 days

Prescriber: **Nancy Wallace MD** **(804) 564-9832**
221 Stream Place, Richmond, VA 23235
Refillable: 0 times QTY: 180 mL R.Ph. Init: RSL
Date filled: 10/21/CY Orig. Date: 10/21/CY Expiration date: 10/21/NY

1. **Has your partner demonstrated this match of the Five Rights correctly? If not, what should she have done differently?**

2. **How would you do this match of the Five Rights in the workplace?**

Exercise: Giving Medication Safely

Answer Key

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

Case Study* 1:** You are a provider taking the MAT course. You have been given the following skill demonstration scenario to practice in pairs: ***"Simon Johnson is a is a ten-month old child in your program. His mother has dropped off a bottle of amoxicillin and a Consent Form for him. It is 2pm. Using the Consent Form, give his medication." *(the Consent Form is on the next sheet).* Your partner is demonstrating, and you are grading her. She reaches the "Five Rights" step in the medication administration process, and does the following:

- *Reads the medication information on the label and the Consent Form, saying out loud "Amoxicillin, Amoxicillin"*
- *Reads the dose information on the label and the Consent Form, saying out loud "1 teaspoon, 1 teaspoon"*
- *Reads the route information on the label and the Consent Form, saying out loud "Oral, by mouth, which is the same thing"*
- *Reads the time information on the label and the Consent Form, saying out loud" 2pm, three times a day"*
- *Reads the child information on the label and the Consent Form, saying out loud "Simon, Simon"*

CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED

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221 Stream Place, Richmond, VA 23235
Refillable: 0 times QTY: 180 mL R.Ph. Init: RSL
Date filled: 10/21/CY Orig. Date: 10/21/CY Expiration date: 10/21/NY

3. **Has your partner demonstrated this match of the Five Rights correctly? If not, what should she have done differently?**
   - *Reads the medication information on the label and the Consent Form, saying out loud "Amoxicillin, Amoxicillin" –* ***she should have read the strength as well as the medication name, so she should have said "Amoxicillin 250 mg per 5 ml, Amoxicillin 250 mg per 5 ml"***
   - *Reads the dose information on the label and the Consent Form, saying out loud "1 teaspoon, 1 teaspoon" –* ***she matched this Right correctly***
   - *Reads the route information on the label and the Consent Form, saying out loud "Oral, by mouth, which is the same thing"-* ***she matched this Right correctly***
   - *Reads the time information on the label and the Consent Form, saying out loud" 2pm, three times a day"- she should have said something like* ***"the label says three times a day, and that's what the Consent Form originally said too, but the parents wrote in 2pm as the time I should give the dose that the child receives while she's at the program, so 2pm is the Right Time to give this dose."***
   - *Reads the child information on the label and the Consent Form, saying out loud "Simon, Simon" –* ***she should have read the child's first and last names, so she should have said "Simon Johnson, Simon Johnson"***

4. **How would you do this match of the Five Rights in the workplace?** *You would not read the Five Rights out loud as you match them, but instead would read them silently. However, you should match them as outlined above.*

Medication Consent Form — Handout 5.8

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
Simon Johnson	**June 1, 20xx**	**none**

4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:
Amoxicillin 250mg/5ml	**1 tsp**	**Oral**

7A. **FREQUENCY**: **3 times per day to administer** **Specific TIME(s)** (e.g. 1p.m.): ***2 pm***

Parent's signature approving Specific Time(s) ***Sally Johnson***

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: **X** See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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.) **Give on an empty stomach**

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

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
X No □Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 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 12 months from the date authorized or this order will not be valid): **14 days**
10/21/CY	

16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**: 804-564-9832
Nancy Wallace, MD	

18. **Licensed authorized prescriber's signature**: Nancy Wallace, MD

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

This is a double-sided form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to **Simon Johnson** (child's name) .	
20. Parent or legal guardian's name (please print): **Jennifer Johnson**	21. Date authorized: 10/1/CY
22. Parent or legal guardian's signature: *Jennifer Johnson*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: 804-555-2784
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Anne Barber**	31. Date received from parent: 10/2/CY
32. Authorized child care provider's signature: *Anne Barber*	

This is a double-sided form

Case Study 2: Your name is Abby Thomas. It is October 2. There is a child in your program named Zara Patel who has severe allergies. Her mother has provided an EpiPen and the Consent Form that follows this page. At 10:00am, Zara develops severe difficulty breathing. You quickly give her an EpiPen injection in her outer left thigh, and she is much improved within moments. While waiting for emergency services to arrive, you document the dose as shown on the Log of Medication that follows.

1. **Did you document this dose correctly? If not, what should you have done differently?**

Case Study 2: Your name is Abby Thomas. It is October 2. There is a child in your program named Zara Patel who has severe allergies. Her mother has provided an EpiPen and the Consent Form that follows this page. At 10:00am, Zara develops severe difficulty breathing. You quickly give her an EpiPen injection in her outer left thigh, and she is much improved within moments. While waiting for emergency services to arrive, you document the dose as shown on the Log of Medication that follows.

Did you document this dose correctly? If not, what should you have done differently?

On the Log of Medication, the medication is identified as Epinephrine (EpiPen), without the strength. This is incorrect. The medication should have been identified as Epinephrine 0.3mg (EpiPen), to match the way the medication is identified on the Consent Form and the pharmacy label.

In the Route, you wrote "by injection", but did not specify the part or side of the body. You should have written "by injection to outer left thigh"

In the Time, you wrote 10:00, but forgot to note that this was a.m.

Medication Consent Form

Handout 5.8

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:** **Zara Patel**	2. Date of birth: **6/23/2009**	3. Child's known allergies: **Bee and wasp stings, peanuts, pet dander, dust**

4. **Name of MEDICATION** (including strength): **Epinephrine 0.3mg (EpiPen)**	5. **Amount/DOSAGE to be given**: **1 injection**	6. **ROUTE of administration**: **Injection in outer thigh**

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
to administer

*Parent's signature approving Specific Time(s)*_____

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters). **Severe swelling of the face and/or throat, severe difficulty breathing**

8. **Possible side effects**: X See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
X Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* 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): Allergies

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
X No □Yes If you checked yes, complete #25 and #27 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?
X No □ Yes If you checked yes, complete #26 and #27 on the back of this form.

14. Date consent form completed: **6/10/CY (current year)**	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid): **6/10/NY**

16. **Prescriber's name** (please print): Joe Black, MD	17. **Prescriber's telephone number**: (555) 555-5555

18. **Licensed authorized prescriber's signature**: *Joe Black, MD*

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to Jose Rodriguez (child's name) .	
20. Parent or legal guardian's name (please print): **Pria Patel**	21. Date authorized: **6/10/CY**
22. Parent or legal guardian's signature: *Pria Patel*	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. 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.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. 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 day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name: **ABC Child Care**	29. Facility Phone Number: 777-777-7777
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print): **Chris Martin**	31. Date received from parent: 6/10/CY
32. Authorized child care provider's signature: *Chris Martin*	

MAT Log of Medication Administration

Handout 5.8

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child's medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD'S NAME _**Zara Patel**_____ MEDICATION (and strength)_**Epinephrine (EpiPen)**_____

COMPLETE FOR ALL DOSES GIVEN					**COMPLETE WHEN SIDE EFFECTS ARE NOTED**		**COMPLETE FOR 'AS NEEDED' MEDICATION ONLY**		**Controlled Substances ONLY**
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Parents notified? and Time	The symptoms the child had that indicated that the medication was needed	Parents notified? and Time	Total Doses Given and Remaining
10/2/CY	**1 injection**	Injection	10:00 AM□ PM□	**Abby Thomas** ***Abby Thomas***		Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes□ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	
			AM□ PM□			Yes □ No□		Yes □ No□	

Complete this section for any medication dose that was not given as written on the child's medication consent form.

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

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 that you may come in contact with:

- ❑ 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[1]

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 two fingers underneath the glove at the wrist and push the glove up and over the balled-up other 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.

[1]Adapted from the SUNY Office of Children and Family Services Health Care Plan, Appendix F.

Prevention of Unintentional Medication Poisoning

Many childhood poisonings, especially in children under five, are due to children ingesting medication that is not intended for them. Many medications taken by adults are dangerous to children. Children's bodies are smaller and their body systems often cannot process the levels of medication found in adult strength medication. Unintentional medication ingestion can cause a child to become extremely ill or even die.

Tips for Keeping Children Safe:

- Store all medication safely
- Medication needs to be kept in an area that is locked and inaccessible, unless designated otherwise by physician's order.
- 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 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

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 that can cause a severe allergic reaction in children:

- Insect or bee venom from bites or stings
- Nuts
- Some medications, especially antibiotics
- Berries
- Eggs
- Wheat
- Milk
- Soy

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

- Difficulty breathing
- Difficulty swallowing
- Wheezing
- Swelling in mouth, tongue and throat
- Severe swelling in the hands, face, lips, tongue and mouth
- Red, itchy, raised patches of skin (hives) across large portion of body
- Massive itching
- Severe vomiting
- Severe diarrhea
- Severe abdominal cramps
- A metallic taste or itching in the mouth
- Rapid heartbeat or racing heart
- A sudden feeling of weakness or dizziness (feeling faint)
- Pale, cool and damp skin
- Passing out

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

Call 911 immediately!

EPIPEN- epinephrine injection
EPIPEN JR- epinephrine injection
Mylan Specialty L.P.

PATIENT INFORMATION and INSTRUCTIONS FOR USE

EPIPEN®
(epinephrine injection, USP) Auto-Injector 0.3 mg
EpiPen® = one dose of 0.3 mg epinephrine, USP 0.3 mg/0.3 mL

EPIPEN JR®
(epinephrine injection, USP) Auto-Injector 0.15 mg
EpiPen Jr® = one dose of 0.15 mg epinephrine, USP 0.15 mg/0.3 mL

For allergic emergencies (anaphylaxis)

Patient Information

Read this Patient Information Leaflet carefully before using the EpiPen® or EpiPen Jr® Auto-Injector and each time you get a refill. There may be new information. You, your parent, caregiver, or others who may be in a position to administer EpiPen or EpiPen Jr Auto-Injector, should know how to use it before you have an allergic emergency.

This information does not take the place of talking with your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about the EpiPen and EpiPen Jr?

1. EpiPen and EpiPen Jr contain epinephrine, a medicine used to treat allergic emergencies (anaphylaxis). Anaphylaxis can be life threatening, can happen within minutes, and can be caused by stinging and biting insects, allergy injections, foods, medicines, exercise, or unknown causes.

   Symptoms of anaphylaxis may include:
   - trouble breathing
   - wheezing
   - hoarseness (changes in the way your voice sounds)
   - hives (raised reddened rash that may itch)
   - severe itching
   - swelling of your face, lips, mouth, or tongue
   - skin rash, redness, or swelling
   - fast heartbeat
   - weak pulse
   - feeling very anxious
   - confusion
   - stomach pain
   - losing control of urine or bowel movements (incontinence)
   - diarrhea or stomach cramps

•dizziness, fainting, or "passing out" (unconsciousness)

2. **Always carry your EpiPen or EpiPen Jr with you because you may not know when anaphylaxis may happen.**

Talk to your healthcare provider if you need additional units to keep at work, school, or other locations. Tell your family members, caregivers, and others where you keep your EpiPen or EpiPen Jr and how to use it before you need it. You may be unable to speak in an allergic emergency.

3. **When you have an allergic emergency (anaphylaxis)**
   - **Use the EpiPen or EpiPen Jr right away.**
   - **Get emergency medical help right away.** You may need further medical attention. You may need to use a second EpiPen or EpiPen Jr if symptoms continue or recur. Only a healthcare provider should give additional doses of epinephrine if you need more than 2 injections for a single anaphylaxis episode.

What are EpiPen and EpiPen Jr?

- EpiPen and EpiPen Jr are disposable, prefilled automatic injection devices (auto-injectors) used to treat life-threatening, allergic emergencies including anaphylaxis in people who are at risk for or have a history of serious allergic emergencies. Each device contains a single dose of epinephrine.
- EpiPen and EpiPen Jr are for immediate self (or caregiver) administration and do not take the place of emergency medical care. You should get emergency help right away after using EpiPen and EpiPen Jr.
- EpiPen and EpiPen Jr are for people who have been prescribed this medicine by their healthcare provider.
- The EpiPen Auto-Injector (0.3 mg) is for patients who weigh 66 pounds or more (30 kilograms or more).
- The EpiPen Jr Auto-Injector (0.15 mg) is for patients who weigh about 33 to 66 pounds (15 to 30 kilograms).
- It is not known if EpiPen and EpiPen Jr are safe and effective in children who weigh less than 33 pounds (15 kilograms).

What should I tell my healthcare provider before using the EpiPen or EpiPen Jr?

Before you use EpiPen or EpiPen Jr, tell your healthcare provider about all your medical conditions, but especially if you:

- have heart problems or high blood pressure
- have diabetes
- have thyroid problems
- have asthma
- have a history of depression
- have Parkinson's disease
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if epinephrine will harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if epinephrine passes into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Tell your healthcare provider of all known allergies.

Especially tell your healthcare provider if you take certain asthma medicines.

EpiPen or EpiPen Jr and other medicines may affect each other, causing side effects. EpiPen or EpiPen Jr may affect the way other medicines work, and other medicines may affect how EpiPen or EpiPen Jr works.

Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

Use your EpiPen or EpiPen Jr for treatment of anaphylaxis as prescribed by your healthcare provider, regardless of your medical conditions or the medicines you take.

How should I use EpiPen and EpiPen Jr?

- Each EpiPen or EpiPen Jr Auto-Injector contains only 1 dose of medicine.
- EpiPen or EpiPen Jr should be injected into the middle of your outer thigh (upper leg). It can be injected through your clothing if needed.
- Read the Instructions for Use at the end of this Patient Information Leaflet about the right way to use EpiPen and EpiPen Jr.
- Your healthcare provider will show you how to safely use the EpiPen or EpiPen Jr Auto-Injector.
- Use your EpiPen or EpiPen Jr exactly as your healthcare provider tells you to use it. You may need to use a second EpiPen or EpiPen Jr if symptoms continue or recur. Only a healthcare provider should give additional doses of epinephrine if you need more than 2 injections for a single anaphylaxis episode.
- **Caution: Never put your thumb, fingers, or hand over the orange tip. Never press or push the orange tip with your thumb, fingers, or hand.** The needle comes out of the orange tip. Accidental injection into finger, hands or feet may cause a loss of blood flow to these areas. **If this happens, go immediately to the nearest emergency room.** Tell the healthcare provider where on your body you received the accidental injection.
- Do not drop the carrier tube or auto-injector. If the carrier tube or auto-injector is dropped, check for damage and leakage. Dispose of the auto-injector and carrier tube, and replace if damage or leakage is noticed or suspected.

What are the possible side effects of the EpiPen and EpiPen Jr?

EpiPen and EpiPen Jr may cause serious side effects.

- **The EpiPen or EpiPen Jr should only be injected into the middle of your outer thigh (upper leg).Do not** inject the EpiPen or EpiPen Jr into your:
    - veins
    - buttocks
    - fingers, toes, hands, or feet

If you accidentally inject EpiPen or EpiPen Jr into any other part of your body, go to the nearest emergency room right away. Tell the healthcare provider where on your body you received the accidental injection.

- Rarely, patients who have used EpiPen or EpiPen Jr may develop infections at the injection site within a few days of an injection. Some of these infections can be serious.

Call your healthcare provider right away if you have any of the following at an injection site:

- redness that does not go away
- swelling
- tenderness
- the area feels warm to the touch

Cuts on the skin, bent needles, and needles that remain in the skin after the injection, have happened in young children who do not cooperate and kick or move during an injection. If you inject a young child with EpiPen or EpiPen Jr, hold their leg firmly in place before and during the injection to prevent injuries. Ask your healthcare provider to show you how to properly hold the leg of a young child during injection.

If you have certain medical conditions, or take certain medicines, your condition may get worse or you may have longer lasting side effects when you use your EpiPen or EpiPen Jr. Talk to your healthcare provider about all your medical conditions.

Common side effects of EpiPen and EpiPen Jr include:

- fast, irregular or "pounding" heartbeat
- sweating
- headache
- weakness
- shakiness
- paleness
- feelings of over excitement, nervousness or anxiety
- dizziness
- nausea or vomiting
- breathing problems

These side effects may go away with rest. **Tell your healthcare provider if you have any side effect that bothers you or that does not go away.**

These are not all the possible side effects of the EpiPen or EpiPen Jr. For more information, ask your healthcare provider or pharmacist.

Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store EpiPen and EpiPen Jr?

- Store EpiPen and 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 your vehicle's glove box and **do not** store in the refrigerator or freezer.
- Examine the contents in the clear window of your 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 your 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 to prevent accidental injection. Keep the blue safety release on until you need to use EpiPen or EpiPen Jr.

•Your EpiPen or EpiPen Jr has an expiration date. Replace it before the expiration date.

Keep EpiPen and EpiPen Jr and all medicines out of the reach of children.

General information about the safe and effective use of EpiPen and EpiPen Jr

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information Leaflet. Do not use the EpiPen or EpiPen Jr for a condition for which it was not prescribed. Do not give your EpiPen or EpiPen Jr to other people.

This Patient Information Leaflet summarizes the most important information about EpiPen and EpiPen Jr. If you would like more information, talk to your healthcare provider. You can ask your pharmacist or healthcare provider for information about EpiPen and EpiPen Jr that is written for health professionals.

For more information and video instructions on the use of EpiPen and EpiPen Jr, go to *www.epipen.com* or call 1-800-395-3376.

What are the ingredients in EpiPen and EpiPen Jr?

Active Ingredients: Epinephrine

Inactive Ingredients: sodium chloride, sodium metabisulfite, hydrochloric acid, and water.

Important Information

•The EpiPen Auto-Injector has a yellow colored label.

•The EpiPen Jr Auto-Injector has a green colored label.

•The EpiPen Trainer has a grey color and contains no medicine and no needle.

•Your auto-injector is designed to work through clothing.

•The blue safety release on the EpiPen and EpiPen Jr Auto-Injector helps to prevent accidental injection of the device. Do not remove the blue safety release until you are ready to use it.

•Only inject into the middle of the outer thigh (upper leg). Never inject into any other part of the body.

•Never put your thumb, fingers, or your hand over the orange tip. The needle comes out of the orange tip.

•If an accidental injection happens, get medical help right away.

•Do not place patient information or any other foreign objects in the carrier tube with the Auto-Injector, as this may prevent you from removing the Auto-Injector for use.

Instructions for Use

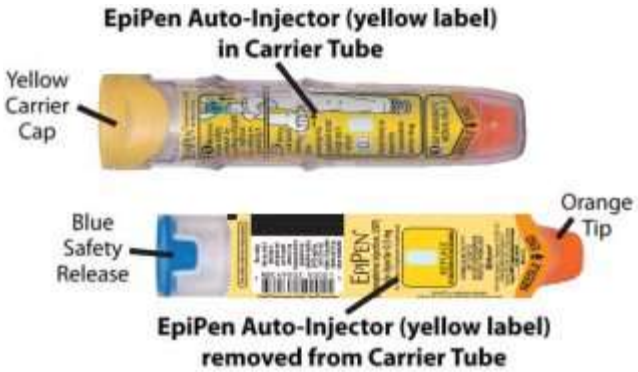
EPIPEN®
(epinephrine injection, USP) Auto-Injector 0.3 mg
EpiPen® = one dose of 0.3 mg epinephrine, USP 0.3 mg/0.3 mL

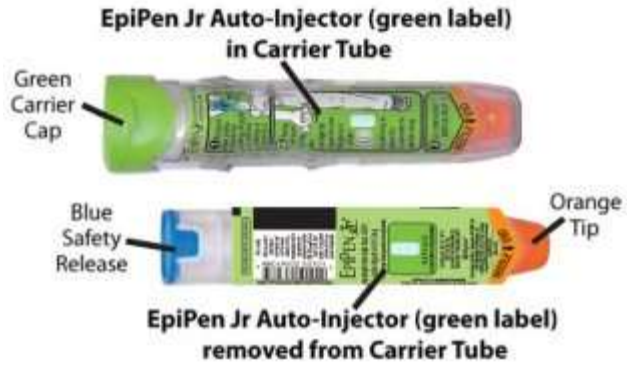
EPIPEN JR®
(epinephrine injection, USP) Auto-Injector 0.15 mg
EpiPen Jr® = one dose of 0.15 mg epinephrine, USP 0.15 mg/0.3 mL

For allergic emergencies (anaphylaxis)

Read these Instructions for Use carefully before you use EpiPen or EpiPen Jr. Before you need to use your EpiPen or EpiPen Jr, make sure your healthcare provider shows you the right way to use it. Parents, caregivers, and others who may be in a position to administer EpiPen or EpiPen Jr Auto-Injector should also understand how to use it as well. If you have any questions, ask your healthcare provider.

Your EpiPen and EpiPen Jr Auto-Injector





A dose of EpiPen or EpiPen Jr® requires 3 simple steps: Prepare, Administer and Get emergency medical help

Step 1. Prepare EpiPen or EpiPen Jr for injection

Remove the EpiPen or EpiPen Jr from the clear carrier tube.

Flip open the yellow cap of your EpiPen or the green cap of your EpiPen Jr carrier tube.

Tip and slide the auto-injector out of the carrier tube.

Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
With your other hand, **remove the blue safety release by pulling straight up** without bending or twisting it**.**

Note:

- The needle comes out of the orange tip.
- To avoid an accidental injection, never put your thumb, fingers or hand over the orange tip. If an accidental injection happens, get medical help right away.

Step 2. Administer EpiPen or EpiPen Jr

If you are administering EpiPen or EpiPen Jr to a young child, hold the leg firmly in place while administering an injection.

Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
Swing and push the auto-injector firmly until it 'clicks'. The click signals that the injection has started.

Hold firmly in place for 3 seconds (count slowly 1,2,3). The injection is now complete.

Remove the auto-injector from the thigh. The orange tip will extend to cover the needle. If the needle is still visible, do not attempt to reuse it.

Massage the injection area for 10 seconds.

Step 3. Get emergency medical help now. You may need further medical attention. You may need to use a second EpiPen or EpiPen Jr Auto-Injector if symptoms continue or recur.

- Take your used auto-injector with you when you go to see a healthcare provider.
- Tell the healthcare provider that you have received an injection of epinephrine. Show the healthcare provider where you received the injection.
- Give your used EpiPen or EpiPen Jr Auto-Injector to the healthcare provider for inspection and proper disposal.
- Ask for a refill, if needed.

Note:

- The used auto-injector with extended needle cover will not fit in the carrier tube.
- EpiPen and EpiPen Jr are single-use injectable devices that deliver a fixed dose of epinephrine. The auto-injector cannot be reused. Do not attempt to reuse EpiPen after the device has been activated. It is normal for most of the medicine to remain in the auto-injector after the dose is injected. The correct dose has been administered if the orange needle tip is extended and the window is blocked.
- Your EpiPen and EpiPen Jr Auto-Injector may come packaged with an EpiPen Trainer and separate Trainer Instructions for Use. The EpiPen Trainer has a grey color. The grey EpiPen Trainer contains no medicine and no needle. Practice with your EpiPen Trainer, but always carry your real EpiPen or EpiPen Jr Auto-Injector in case of an allergic emergency.
- If you are administering EpiPen or EpiPen Jr to a young child, ask your healthcare provider to show you how to properly hold the leg in place while administering a dose.
- Do not try to take the EpiPen or EpiPen Jr Auto-Injector apart.

This Patient Information and Instructions for Use has been approved by the U.S. Food and Drug Administration.

Auto Injector (EpiPen®) Procedure Guide

- ❑ **If another employee is present,** have them call 911 to get emergency help for the child while you are administering EpiPen.
- ❑ **Quickly match the Five Rights**
- ❑ **Prepare the EpiPen auto-injector**
    - **Flip open the yellow cap** of the EpiPen or the green cap of the EpiPen Jr. carrier tube.
    - **Slide the auto-injector out** of the carrier tube.
    - **Grasp** the auto-injector in your fist with the **orange tip pointing downward**.
    - With your other hand, **remove the blue safety release** by pulling straight up without bending or twisting it.
    - **NEVER put your thumb, fingers or hand over the orange tip**.
- ❑ **Administer** the medication
    - **Hold the child's leg firmly in place** before and during the injection, so it cannot move**.**
    - **Place the orange tip of the auto-injector** against the middle of the child's outer thigh, pointed straight into the thigh.
    - **Swing and push the orange tip firmly** against the outer thigh **until you hear a click.**
    - **Hold the EpiPen firmly in place against the thigh for 3 seconds** to deliver the drug (count slowly "one – two – three"). 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.
- ❑ If 911 has not already been called, **call 911 right away** to get emergency medical help for the child.
    - Send the used auto-injector with the child to the emergency room.

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FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Handout 7.6

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

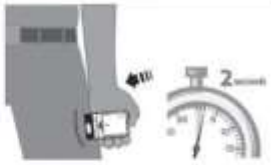
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

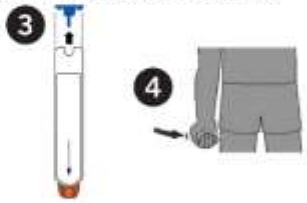
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



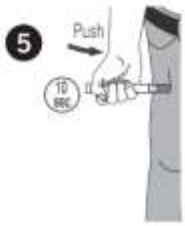
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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Next Steps

MAT Certificate

Once you successfully complete the MAT course, your MAT Certificate will be available in your Online Certificate account within 2 weeks. Your trainer will issue you a MAT Training receipt today which is good for 60 days.

IT IS YOUR RESPONSIBILITY to confirm that your MAT Certificate is posted correctly to your Online Certificate account, that the child day program you work for is recorded correctly on your certificate, and that you notify us if any of the information on your certificate changes. Handout 8.2 tells you how to access and update your certificate.

IT IS ALSO YOUR RESPONSIBILITY to provide a printout of your MAT Program Online Certificate to your employer for Licensing purposes. Handout 8.2 tells you how.

Your MAT certificate:

- is valid for three years
- only allows you to give medication in a child care or a VCPE member private school setting.
- specifies that English is the language in which you can accept permissions and instructions from the child's parent and health care provider. You cannot accept medication permissions and instructions in any other language. This includes package inserts or related materials.

Authorization to Administer Medication in a Day Care Program

In addition to a valid MAT certificate, you must meet the following requirements before you will be authorized to administer medication in a day care program:

- be 18 years old
- have a current first aid certification that covers the ages of the children in your care
- have a current CPR certification that covers the ages of the children in your care

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 the MAT Online Learning Center website: mat-elearning.medhomeplus.org. Each handout is dated so you can check to see if you have the most current version.

Certificate Renewal

If you hold a current MAT Certificate, you are eligible to take the streamlined **MAT First Renewal Course** for your **first** renewal of that certificate. ***The MAT First Renewal Course is***

designed for providers who regularly administer medications using the MAT method, so are familiar with the process and need little or no review.

If you prefer more review, ***you may choose to take the MAT Independent Study course or the full-day MAT classroom course to renew your certification***.

The MAT First Renewal Course option is only available to providers renewing their MAT certification for the FIRST TIME after being certified through the full-day MAT classroom course or the MAT Independent Study course.

Providers who successfully complete the MAT First Renewal Course will receive a MAT First Renewal Certificate. Providers holding a MAT First Renewal Certificate will be required to take the MAT Independent Study course or the full-day MAT classroom course when it's time for their next renewal.

For those who choose the MAT First Renewal course, this course has two parts, like the current MAT Independent Study course.

- MAT First Renewal Part 1 is taken online and is free. It includes registration in the MAT IS course so that providers wishing to do so can review this content to prepare for recertification. However, this is optional. Part 1 also includes a mandatory online test. Providers who pass this online test are issued a MAT First Renewal Part 1 Completion Certificate. As with the MAT IS course, this certificate does not authorize you to give medications, but serves as your admission ticket to the MAT First Renewal Part 2 live skills demonstration session.
- MAT First Renewal Part 2 is taken in a classroom setting. There is no classroom practice time provided in this session. During the MAT First Renewal Part 2 session, participants perform the MAT liquid measurement, EpiPen and randomized skills demonstrations. Successful completion of this class will renew your MAT certificate for three years.

Additional Resources

- MAT Trainer:_____
- Contact number:_____
- Medication Administration Training (MAT) Program:
    - Email: support@mat.freshdesk.com
    - Phone: 804-330-5030.

- Other:_____

For Providers:

Accessing Your MAT Program Online Certificate and Keeping It Current *(as of 8/26/19)*

IT IS YOUR RESPONSIBILITY to: 1) confirm that your MAT Program Certificate is posted correctly to your MAT Online Certificate account, 2) confirm that the child day program you work for is recorded correctly on your certificate, and 3) notify the MAT Program if any of the information on your certificate is incorrect or changes.

YOU MUST print a copy of your MAT Online Certificate Report and give it to your employer for Licensing purposes.

- **Your MAT Online Learning Center account:** The individual email address that you provided when you registered for the MAT class is your **username** for your account on the MAT Online Learning Center system.
    - **This email address must be a working, individual (not shared) email address.** We will email your temporary password to this email address. For security reasons, **we will not create multiple accounts with the same email address.**
    - **You should register with the SAME email address each time you take a MAT class,** so that all your MAT Program certificates will be visible in the SAME MAT Online Certificate account.
    - **How can your manager/administrator see your certificate(s)?** Your administrator can get a special **administrator-level MAT Online Certificate account**, which gives her access to all the current MAT Program certificates for the providers working at her program. **Handout 8.3** provides easy instructions on how to open this account. **Please give this handout to your manager!**
- **Receiving your temporary password (for new accounts):** Within 2 weeks of your date of training, we will email your temporary password to the email address that you gave your trainer when you registered for the class.
- **To log in to your MAT Online Certificate account,** go to the MAT Program website (mat.medhomeplus.org) and click the **View Your Certificate(s)** link in the left column menu.
    - The system will ask for your **username and password.** Your username is the email address you gave your trainer when you registered for this class. The first time you log in, enter the temporary password we have emailed to you. ***HINT: Please "copy-paste" the temporary password in***, to avoid typos! The system will

prompt you to change your password to anything you like. You can use a password you've used before. Please write it down in a secure place! But if you lose it, we are happy to reset it for you.

- ❑ **What if there's a problem with my MAT Online Certificate?**
  - **If there are any issues with your certificate**, such as if it does not appear in your MAT Online Certificate account within 2 weeks or if your name is spelled wrong, **report the problem** to the MAT Program. Just go to the **MAT Program website** (mat.medhomeplus.org), click the green **Need Help** tab at the top of the page, select **Online Certificate Problem** as the Type of Problem, fill in the form that pops up and submit it. Our customer service staff will be happy to help you.

- ❑ **How do I print a copy of my MAT Online Certificate Report?**
  - Just log in to your account as outlined above. As soon as you reset your password, a **"See My Certificates"** button will appear. Click that button and your Certificates Report will appear. Click the **PRINT** icon on that report to print it.

- ❑ **What if I forget my username or password or need to change them?**
  - **Report the problem** to the MAT Program as outlined above. For quickest service, click **Forgot Username and/or Password** as the Type of Problem and fill in the form that pops up.

- ❑ **What if I change employers?**
  - **Your MAT Program certificate is valid for three years at any child day program in Virginia.** If you change child day program employers, **please report this change** to the MAT central office so that your certificate will be reported in the correct child day program. Just click the green **Need Help** tab at the top of the **MAT Program website** *(at the web address given above),* Select **Online Certificate Problem** as the Type of Problem, and fill in the form that pops up to report this change.

- ❑ **What if I want a "traditional" paper certificate?**
  - ***For certifications earned from 8/26/19 on, a traditional, full-page paper MAT Program Certificate is not required for Licensing purposes. A printout of your MAT Online Certificate Report will meet Licensing requirements for these certifications***. However, by 9/30/19, a Print Certificate feature will be added to the MAT Online Certificate system enabling you to print a full-page version of each of your current MAT Program certificates, should you choose to do so.

Handout 8.3

For Child Day Program Administrators:

Accessing Your Employees' MAT Program Online Certificates *(as of 8/26/19)*

As of 8/26/19, we have converted from paper to online MAT Program certificates. This new system has been created in response to growing problems with mailed certificate delivery. Please bear in mind that this is a new system and there will be a transition period.

Your employees' current MAT Program certificates (for dates of training 8/26/19 and later) are visible to you online. No other child day program administrators can see this data. To see these certificates, you must open an Administrator account on the MAT Online Certificate system. **Only one Administrator account can be created for each child day program location.**

Documenting MAT certification compliance: MAT Program certificates earned before 8/26/19 can be documented using the paper MAT Program Certificates issued for those classes. **For Licensing purposes, all current MAT Program certificates earned from 8/26/19 on MUST be documented with a (free) printout of each provider's certificate record in his or her employee file.** Providers who have attended MAT classes from 8/26/19 on have received instructions on how to access and print this record after each MAT class they pass.

For your convenience, once your Administrator account is set up, you can **log in to your MAT Online Certificate account** and see the MAT Program certificate records for all your employees. Here's how easy it is:

1) **Open your Administrator account**– it takes just a moment to request your account. *See below for instructions.*
2) **Log in to your Adminstrator account and check the MAT Program certificates displayed there** – let us know of any problems and we'll fix them right away.

To open your Administrator account and see your program's MAT certificates:

- **Request the account:** Go to the **MAT Program website** (mat.medhomeplus.org), click the green **Need Help** tab at the top of the page, and in Type of Problem, click **For Administrators – Request New Account.** Fill in the form that pops up and submit it.
  - **IMPORTANT-** You must provide **an individual (not shared) email address,** which will serve as the username for this account. For security reasons, to protect your data, **we will not create multiple accounts with the same email address.**
- **Receiving your username and password:** To protect your data, the MAT Program will verify your identity as administrator for your child day program location. Then we'll create your account and notify you by email.

- **Seeing your certificates:** After receiving your new account notification email, go to the MAT Program website (mat.medhomeplus.org), click the **See My Certificates** link in the menu. Log in, and **you should see all your employees' current MAT Program certificates earned from 8/1/19 onward.**

Frequently Asked Questions:

- **What if I forget my username or password or need to change them?**
  - **Let us know** by clicking the green **Need Help** tab at the top of the **MAT Program website** *(mat.medhomeplus.org)*, selecting **Forgot Username and/or Password** as the Type of Problem, and filling in the form that pops up. Our customer service staff will help you promptly.

- **What if there are inaccuracies in the MAT Program certificates listed for my program location?**
  - **MAT Certificates received prior to 8/1/19 will not initially appear on the MAT Online Certificate system. These certificates can be documented with the paper certificates issued for those classes.** However, we will be happy to work with you to connect these pre-8/1/19 certificate records to your Administrator account so you can see all current MAT Program certificates for your child day program location in one place.

  - **If the list of post-8/1/19 MAT Certificates for your program location is incorrect:** Your Administrator account should show all MAT Program certificates received from 8/1/19 on by providers who work at your program location. If there are any inaccuracies, we will be happy to quickly correct the problem. Just go to the **MAT Program website** (mat.medhomeplus.org), click the green **Need Help** tab at the top of the page, select **Online Certificate LIST Problems** as the type of problem, and fill in the short form.

- **How can we get traditional paper MAT Program certificates?** Traditional full-page paper certificates for certifications earned from 8/26/19 onward are **not required** for Licensing purposes. However, by 9/30/19, we will add a feature to the MAT Online Certificate system that will enable providers to print full-page versions of each of their current MAT Program certificates if they wish to do so.

- **My program has multiple locations and I want to see them all in one report:** You can request custom, multi-location reporting by submitting an Online Certificate LIST Problems request per the instructions above, describing your needs.

Procedure Guide:
Applying Medication Topically

Topical medication comes in many forms such as:

- gels
- creams
- ointments
- aerosols
- medicated patch

In addition to any medication-specific instructions, follow these steps when applying medication topically *(except for medicated patches):*

- ❑ If indicated, **shake** the medication
- ❑ For aerosols, read the container's label for the recommended **distance to hold the spray** from the child's skin
- ❑ For topical medications, you **make the decision on wearing gloves**. You should wear gloves if:
  - The skin on your hands is cut, scabbed or broken
  - The medication should not touch your skin
  - You feel more comfortable wearing gloves to give the medication
- ❑ For non-aerosol topical medication, **squeeze the correct amount of medication into your hand**
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Apply or spray the medication** evenly on the skin
- ❑ **If you need to apply more medication**, change gloves (if wearing gloves) and squeeze the medication into your hand
- ❑ **VERY IMPORTANT:** When spraying any topical medication, **shield the child's face or have the child turn away** from the spray and close his/her eyes **to avoid injury to the child** that could result from getting spray in the child's face or eyes
- ❑ If wearing gloves, **remove gloves and discard using the appropriate technique.**

If applying a medicated patch:

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 steps when applying a medicated patch:

- ❑ For medicated patches, you **make the decision on wearing gloves**. You should wear gloves if:
  - The skin on your hands is cut, scabbed or broken
  - The medication should not touch your skin
  - You feel more comfortable wearing gloves to give the medication
- ❑ **If there is a used patch on the child**:
  - **Remove** the used 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 your dirty gloves, if wearing gloves.
  - If wearing gloves, put on new gloves.
- ❑ **Choose the area** as directed 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. Unless otherwise indicated, the **upper arm or upper back** areas are good places to put a patch.
- ❑ **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.
- ❑ **Remove a patch** from the box and compare it to the medication label to make sure it is the correct medication.
- ❑ Before you put the new patch on the child, **write the date and time on it** with a waterproof pen or marker.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Apply the patch** by peeling off any backing on the patch and hold the patch by the edges. Smooth the patch onto the skin. Check to make sure it is adhering well.
- ❑ If wearing gloves, **remove gloves and discard using the appropriate technique**.

Procedure Guide:
Giving Sprinkle Medication

In addition to any medication-specific instructions, follow these steps to give medication by sprinkles:

- ❑ For oral medications, you **make the decision on wearing gloves**, unless you are applying medication to the gums.
- ❑ For oral medications other than those applied to the gums, you should wear gloves if:
  - The skin on your hands is cut, scabbed, or broken
  - The medication should not touch *your* skin
  - You feel more comfortable wearing gloves to apply the medication.
- ❑ When removing capsules from a container, **avoid touching them with your hands**.
  - **Pour the number of 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.
- ❑ If you need to put medication in food, **use only a small amount of food** to be sure the child can finish it all.
  - Check the medicine bottle, label and package insert for any possible **food interactions** so you do not mix the medication with a wrong food.
- ❑ Place a small amount of food into a cup or bowl.
- ❑ Open the medication capsule(s) and empty the contents onto the small amount of food. Be sure to empty all of the medication from the capsule.
- ❑ **Mix** the contents of the capsule with the food.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time
- ❑ **Give the medication with food** to the child.
- ❑ **Watch the child take the medication and look in the child's mouth and under the tongue** to make sure the child swallowed it.
- ❑ If you wore gloves, **remove gloves and discard using the appropriate technique**.

Procedure Guide:
Giving Tablets or Capsules

In addition to any medication-specific instructions, follow these steps to give medication by tablet or capsule:

- ❑ For oral medications, you **make the decision on wearing gloves**, unless you are applying medication to the gums.
- ❑ For oral medications other than those applied to the gums, you should wear gloves if:
  - The skin on your hands is cut, scabbed, or broken
  - The medication should not touch *your* skin
  - You feel more comfortable wearing gloves to apply the medication.
- ❑ When removing pills or capsules from a container, **avoid touching them with your 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.
- ❑ **Never crush or split medication or open capsules** unless instructed to do so on the Consent Form or the medication label.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Give the medication** to the child.
- ❑ **Give a cup of water** to the child to help her 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.
- ❑ If you wore gloves, **remove gloves and discard using the appropriate technique**.

Procedure Guide:
Measuring and Giving Liquid Medication By Cup

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 substitute household items, such as household baking spoons, teaspoons, measuring cups, for dosing devices. The parent must supply a dosing device with the correct measurement (teaspoons, tablespoons, milliliters, cc's or ounces) identified in the health care provider's instructions. Due to the potential for error, you should never convert a dose from one measurement to another.

Measuring the medication:

- ❑ **Identify the desired measurement** on the medicine cup.
    - If you want to mark the correct dose on the tool, be sure to mark next to the measurement line, not over it
- ❑ If indicated, **shake** the medication.
- ❑ **Pour the liquid medication** into the cup to the desired level.
    - To avoid getting medication on the label, pour the medication out of the bottle away from the label
- ❑ **Check the accuracy of your measurement** by putting the cup with medication on a flat surface and checking it at eye level.
    - **If you pour too much into the cup**, unless otherwise instructed, you can return this leftover medication to the original container if it has not been contaminated.

Giving the medication:

- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Hand the medicine cup to the child** and assist or watch him/her drink the medicine.
- ❑ **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.

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 with dishwashing soap and water.

Procedure Guide:
Measuring and Giving Liquid Medication by Spoon

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 substitute household items, such as household baking spoons, teaspoons, measuring cups, for dosing devices. The parent must supply a dosing device with the correct measurement (teaspoons, tablespoons, milliliters, cc's or ounces) identified in the health care provider's instructions. Due to the potential for error, you should never convert a dose from one measurement to another.

Measuring the medication:

- ❑ **Identify the desired measurement** on the medicine spoon.
    - If you want to mark the correct dose on the tool, be sure to mark next to the measurement line, not over it
- ❑ If indicated, **shake** the medication.
- ❑ **Pour the liquid medication** into the spoon to the desired level.
    - To avoid getting medication on the label, pour the medication out of the bottle away from the label
- ❑ **Check the accuracy of your measurement** by holding the spoon with medication at eye level and checking it.
    - **If you pour too much into the spoon**, unless otherwise instructed, you can return this leftover medication to the original container if it has not been contaminated.

Giving the medication:

- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  □ child's full name □ medication and strength □ dose □ route □ time

- ❑ Put the dosing spoon in the child's mouth and **slowly give the medicine,** to help avoid the child spitting out the entire 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.

Cleaning Medication Tools

Always keep medication tools clean. This will help avoid giving a wrong dose and prevent possible infections. You can wash dosing spoons with dishwashing soap and water.

Procedure Guide:
Measuring and Giving Medication by Oral Syringe

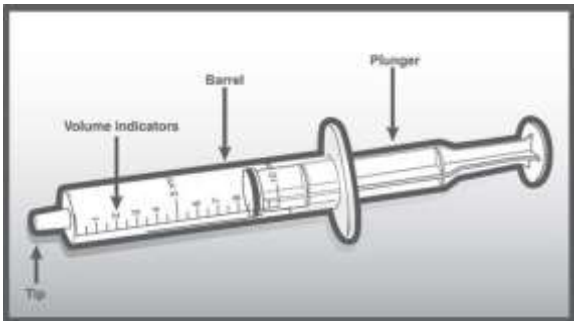
The child's full name must be written on the measuring tool. The tool must also have the exact measurement that matches the amount of medication the instructions tell you to give. Do not substitute household items, such as household baking spoons, teaspoons, measuring cups, for dosing devices. The parent must supply a dosing device with the correct measurement (teaspoons, tablespoons, milliliters, cc's or ounces) identified in the health care provider's instructions. Due to the potential for error, you should never convert a dose from one measurement to another.

Measuring the medication:

- ❑ **Identify the desired measurement** on the oral syringe.
  - o If you want to mark the correct dose on the tool, be sure to mark next to the measurement line, not over it
- ❑ If indicated, **shake** the medication.
- ❑ Make sure the **plunger is pushed all the way down** into the syringe.
  - o *If the bottle has an adapter*, put the syringe in the adapter and pull the syringe plunger until you get the correct dose.
  - o Follow any other directions provided.

—OR—

  - o *If the bottle does **not** have an adapter*, pour a *small* amount of medication into a clean disposable cup.
  - o Place the tip of the syringe into the liquid in the disposable cup.
  - o Pull the plunger to draw up the right dose of medication. You may return any unused medication to the medication bottle.
- ❑ **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 pointed toward the ceiling.
    - To remove any air bubbles, either tap the syringe until the air bubbles are gone, or pull the plunger down past the air bubble making a big pocket of air, then slowly push the plunger up
    - Make sure all air bubbles are gone.
- **Check the syringe at eye level** to make sure the dose is correct.

Giving the medication:

- Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- **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. Never aim the syringe directly down the child's throat as this can cause choking.

Cleaning Medication Tools

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

Procedure Guide:
Giving Medication by Inhaler

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

In addition to any medication-specific instructions, follow these steps to given medication by inhaler:

- ❑ For inhaler medications, you **make the decision on wearing 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 mucus**
  - the medication to be given should not touch ***your*** skin
  - you feel more comfortable wearing gloves to apply the medication.
- ❑ **Remove the inhaler cap** and **check the mouthpiece** for foreign objects before using
- ❑ If indicated, **shake** the medication
- ❑ Hold the inhaler **between your index finger and thumb**.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Have the child put the inhaler mouthpiece into her mouth** and close her lips loosely around it. *(To be consistent, use the same technique that the child's parents use at home)*
- ❑ With the child's **head tilted slightly back**, ask her to take a **slow deep breath**.
  - As she does this, **press down on the inhaler canister to release the spray**.
- ❑ Have her **hold her breath** for a few seconds, then exhale with lips pursed.
- ❑ Always **watch the child use the inhaler**.
- ❑ **If the child needs more than one puff**, follow the instructions for how long to wait before giving another puff.
- ❑ Have the child **rinse her mouth with water and then spit it out**. Do not have the child swallow the water.

- ❑ 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.
- ❑ **Wipe off the inhaler mouthpiece** with a clean tissue and replace the cap.
- ❑ If wearing gloves, **remove gloves and discard using the appropriate technique**.

Care of Inhaler

The inhaler mouthpiece and spacer (if any) should be washed in warm soapy water as specified in the package instructions at least once a week. However, if the child has a cough, the mouthpiece and spacer should be washed daily.

Procedure Guide:
Giving Medication by Inhaler with Spacer

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

In addition to any medication-specific instructions, follow these steps to given medication by inhaler:

- ❑ For inhaler medications, you **make the decision on wearing 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 mucus**
  - the medication to be given should not touch ***your*** skin
  - you feel more comfortable wearing gloves to apply the medication.
- ❑ **Remove the inhaler cap** and **check the mouthpiece** for foreign objects before using
- ❑ If indicated, **shake** the medication
- ❑ **Attach the spacer** to the inhaler.
- ❑ Hold the inhaler **between your index finger and thumb**.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Have the child put the spacer mouthpiece into her mouth** and close her lips loosely around it. If a mask is attached to the spacer, place the mask on the child's face, covering both the nose and mouth.

- ❑ With the child's **head tilted slightly back**, ask her to take a **slow deep breath**.
  - As she does this, **press down on the inhaler canister to release the spray**.
  - Keeping the spacer mask over the child's nose and mouth, or the spacer mouthpiece still in the child's mouth, have her **hold her breath** for a few seconds, then breathe out into the spacer.
  - Then, have her continue breathing in and out into the spacer for at least **three more cycles** to be sure all the medication in the spacer chamber is used.

- ❑ Always **watch the child use the inhaler**.
- ❑ **If the child needs more than one puff**, follow the instructions for how long to wait before giving another puff. **If an additional puff is not needed, wait 1 minute.**
- ❑ Have the child **rinse her mouth with water and then spit it out**. Do not have the child swallow the water.
- ❑ **Wipe off the mask or inhaler mouthpiece** with a clean tissue and replace the cap.
- ❑ If wearing gloves, **remove gloves and discard using the appropriate technique**.

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.

Care of Inhaler

The inhaler mouthpiece and spacer (if any) should be washed in warm soapy water as specified in the package instructions at least once a week. However, if the child has a cough, the mouthpiece and spacer should be washed daily.

Procedure Guide:
Giving Medication by Nebulizer

There are many different kinds of nebulizers available, each with different parts and steps to follow. Be sure you know how to assemble and use the nebulizer for this child.

Check to make sure you have all of the necessary nebulizer parts.

- ❑ **Turn on the machine** to make sure it is working, then turn it off.
- ❑ **Attach the tubing and nebulizer parts to the compressor** per the manufacturer's instructions.
- ❑ Some medication used in a nebulizer must be mixed with a liquid, such as normal saline, before it is used. Others will come in a single-dose vial. Be sure **to read the healthcare provider instructions included on the Medication Consent Form carefully to see if you need to mix the medication before it is used.**

- ❑ **Put on gloves.**
- ❑ **Remove the medication/vial from its container and compare it** to the medication container.
- ❑ **Pour the prescribed amount of medication into the nebulizer medication cup**. If the medicine needs to be diluted, carefully follow the health care provider instructions on how to dilute the medication.
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Give the medication**
  - **Turn on** the nebulizer machine.
  - **Make sure you see a mist coming out of the mouthpiece** before placing it into the child's mouth or placing the mask over the child's nose and mouth.
  - **Place the mouthpiece** in the child's mouth or **place the mask** over the child's nose and mouth.
  - Have the child **breathe normally**.

- ❑ **Watch the child during the entire treatment** to make sure (s)he gets all of the medication.

  - The treatment is done when **no more liquid is** in the medication cup.
  - **Take off gloves and discard in an appropriate manner.**

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.

Care of a Nebulizer Machine

Nebulizer machines and parts require special care and cleaning to reduce the risk of harmful bacterial growth.

These are general principles for caring for a nebulizer machine. The steps may vary based on the type of nebulizer machine being used. Always follow the manufacturer's instructions when cleaning a nebulizer machine.

After each use:

- **Disconnect** the mask or mouthpiece and the medicine cup from the tubing.
- **If you see moisture inside the tubing**, run the machine for 10-20 seconds to dry the inside of the tubing.
- Disconnect the tubing from the nebulizer and place it in a **sealable plastic bag**.
- The tubing should **never be rinsed or put in water**.
- **Wash the remaining nebulizer parts** with a mild dishwashing soap and warm water.
- **Rinse** the nebulizer parts under a strong stream of warm running water for at least thirty seconds. If possible, use distilled or sterile water as a final rinse.
- **Shake off** excess any water.
- Allow the nebulizer parts to air dry on a clean cloth or paper towel. The parts may be dried with a lint free towel.
- **Once dry, place the remaining nebulizer parts into the sealable plastic along with the tubing.**

Procedure Guide:
Giving Nasal Spray

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

In addition to any medication-specific instructions, follow these steps to give nasal spray:

- ❑ **Put on gloves**.
- ❑ It's a good idea to have the child **blow his/her nose or wipe away** any visible mucous.
- ❑ If indicated, **shake** the medication.
- ❑ Position the child's head **tilted slightly back.**
- ❑ Compare the child's medication consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Close the other nostril** as you give the dose so the child can breathe the medication in correctly
- ❑ **Place the tip of the sprayer** about ½ inch into the nostril.
- ❑ Aim the sprayer straight up the nose and towards the inner corner of the child's eye.
- ❑ Ask the child to **hold her breath while you quickly squeeze the sprayer** to release the spray.
- ❑ **Remove** the sprayer.
- ❑ Ask the child to **breathe out through her mouth.**
- ❑ **If the other nostril needs medication**, wipe the sprayer tip and follow the same process for the other nostril.
- ❑ Ask the child to **keep her head back and to avoid blowing her nose** for a minute or two if able. This will give the medicine time to work
- ❑ **Wipe the sprayer tip off** after giving the dose.
- ❑ **Remove gloves and discard** using the appropriate technique.

Procedure Guide:
Giving Eye Drops

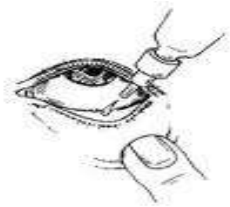
In addition to any medication-specific instructions, follow these steps when giving eye drops:

- ❑ When giving medication in 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.**
- ❑ **Clean the child's eye** with a clean tissue, wiping from the inner corner to the outside edge.
- ❑ **If they are soiled, remove gloves** and put on a new pair of gloves.
- ❑ **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.
- ❑ Compare the consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **If needed, warm the drops** between the palms of your hands.
- ❑ If the child can follow directions, **ask the child to look up and keep his eye open**. With one hand, **make a pocket** in the child's lower eyelid
- ❑ Using your other hand, rest your palm on the child's forehead to keep your hand steady. **Bring the medicine to the child's eye** coming from the outside of where he can see.
- ❑ **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 medicine completely misses his eye, give the dose again.** If any amount gets in the eye, don't give another dose.

- ❑ The child will naturally close his eye. **Ask him to keep his eye closed for a minute or two**. Wipe off any liquid that spills out of the eye with a clean tissue. If this occurs, you do not need to give the dose again.
- ❑ **If the second eye needs medication**, put on clean gloves and repeat the procedure.
- ❑ **Replace the cap** on the medication
- ❑ **Correctly remove and discard gloves.**

Procedure Guide:
Giving Eye Ointment

In addition to any medication-specific instructions, follow these steps when giving eye ointment:

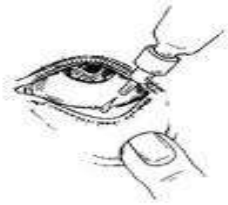
- ❑ When giving medication in only one eye, **be careful to put the medication into the correct eye.** Remember that if the child is facing you, the child's eye on your left side is actually the child's right eye, so be sure you know which eye is the correct eye.

- ❑ **Put on gloves.**
- ❑ **Clean the child's eye** with a clean tissue, wiping from the inner corner to the outside edge.
- ❑ **If they are soiled, remove gloves** and put on a new pair of clean gloves.
- ❑ **Have the child sit or lie down.** Older children can usually sit for eye medication. You may find it easier to have a young child lie down.
- ❑ Compare the consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

If needed, warm the medication between the palms of your hands.

- ❑ If the child can follow directions, **ask the child to look up and keep his eye open**. With one hand, **make a pocket** in the child's lower eyelid
- ❑ Using your other hand, rest your palm on the child's forehead to keep your hand steady. **Bring the medicine to the child's eye** coming from the outside of where he can see.
- ❑ **Put the medication in the pocket** of the child's lower eyelid. **Do *not* place directly into the eye.**
- ❑ Start applying the ointment from the inner part of the lower eyelid that is closest to the child's nose and go outward toward the child's ear. **Do not touch the child's eye with the ointment tip.**



- Very often children blink when getting eye medication. **If the medicine completely misses his eye, give the dose again.** If any amount gets in the eye, don't give another dose.
- The child will naturally close his eye. **Ask him to keep his eye closed for a minute or two**. Wipe off any ointment that spills out of the eye with a clean tissue. If this occurs, you do not need to give the dose again.
- **If the second eye needs medication**, put on clean gloves and repeat the procedure.
- **Replace the cap** on the medication
- **Correctly remove and discard gloves.**

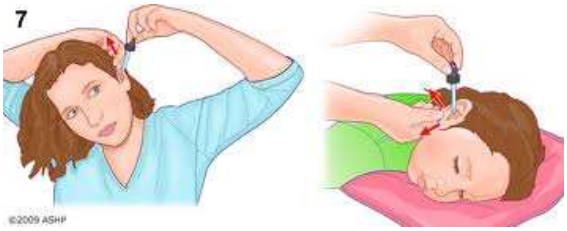
Procedure Guide:
Giving Ear Drops

In addition to any medication-specific instructions, follow these steps to give medication in the ear:

- ❑ For medications given in the ear, you **make the decision on wearing gloves**. You should wear gloves if:
  - The skin on your hands is cut, scabbed or broken
  - The medication should not touch your skin
  - You feel more comfortable wearing gloves to give the medication
- ❑ **If the outer part of the child's ear has some crusting or earwax**, you should gently remove this with a clean tissue. 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.
- ❑ **Have the child sit down, tilting her ear up or have the child lie down on her side** so the ear is pointed up. Be sure that you are giving the medication **in the correct ear**.
- ❑ Compare the consent form against the medication label to match the **Five Rights** just before administering the medication to the child.

  ☐ child's full name ☐ medication and strength ☐ dose ☐ route ☐ time

- ❑ **Draw the medication into the dropper**
- ❑ 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.

- ❑ Wipe off any excess drops on the outside of the ear. **If the dose completely misses her ear,** administer the dose again. *If any portion of the drop gets into the ear, do not administer the dose again.*
- ❑ **Have the child stay on her side for a few minutes** if possible. You should hold the infant so that the ear drops will not flow out of the child's ear.
- ❑ **Replace** the dropper.
- ❑ **If gloves were worn, remove the gloves and discard using the correct technique.**

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