

TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
2020/2021 MEDICAL FORM INSTRUCTIONS FOR INHALER

According to New York State Office of Children and Family Services, these are the only forms that will be accepted and must be completed entirely. Unfortunately, School District forms cannot be accepted. All medical forms (a total of 6 pages) are due in our office no later than August 1st.

These signatures are valid for one-year from date signed.

Please follow instructions below:

1. Medical Report Form (1 Page): Must be filled out completely, signed, stamped and dated by Physician. Physical is not required if child has had one within the last 2 years.
2. Medication Authorization Form for Administration of Medication (1 Page): Bottom portion (Self Medication Release Form) must be signed and dated by parent. This signature is valid for one-year from date signed.
3. Medication Consent Form (2 Pages): Physician must fill out in its entirety and sign bottom of page 1, parent must review for accuracy and sign top of page 2. Section #31-35 does not have to be completed unless applicable. *The information written on these pages **MUST** match the information printed on the prescription label.* (see below).
4. Individual Health Care Plan- Inhaler/Asthma: (2 Pages):
 - Page 1: Must be filled out by parent in its entirety. *Parent must outline a detailed description of symptoms, when the inhaler should be given, instructions on use, and what steps should be followed after the child administers his/her inhaler.*
 - Page 2: Parent must sign and date bottom portion of form.

******IMPORTANT******

INHALER WILL NOT BE ACCEPTED IF:

- THE INHALER IS EXPIRED
- THE INHALER IS NOT IN THE ORIGINAL CONTAINER WITH THE CHILD'S NAME ON THE PRESCRIPTION LABEL
- THE (MEDICATION NAME/DOSAGE IF APPLICABLE) DOES NOT MATCH.
EXAMPLE: THE INFORMATION ON THE INHALER AND PAPERWORK MUST READ EXACTLY THE SAME!! THERE WILL BE NO EXCEPTIONS.

All forms must be filled out according to instructions or they will not be accepted as per OCFS Regulations.

TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE PROGRAM 2020/2021 MEDICAL FORM

NAME OF CHILD: _____ NAME OF SCHOOL: _____

Medical Report of Child in Day Care

To Be Completed By Child's Physician, Physician's Assistant or Nurse Practitioner (Other Than A Relative)

Date of Birth: / /

Date of Last Exam: / /

HEALTH SPECIFICS:

COMMENTS:

<input type="checkbox"/> Yes <input type="checkbox"/> No Are there any allergies? If yes, specify what the child is allergic to.	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is medication regularly taken? (Specify drug & condition)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is a special diet required? (Specify diet & condition)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are there any hearing, visual or dental conditions requiring special attention?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are there any medical or developmental conditions requiring special attention?	

Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally? ___ Yes ___ No

If yes, describe any additional training, procedures or competencies the day care program staff will need to care for this child. _____

Date of most recent tetanus booster: / /

Summary of most recent physical (including special recommendations to Day Care Provider):

At the time of the child's last exam and on my knowledge of the above named child, I find that he or she is free from contagious and communicable disease and is able to participate in day care.

Yes No

Signature of Examiner: _____ Address: _____

Please Print Name: _____ City, State, Zip: _____

Title: _____ Phone: _____ Date: ____/____/____

**Town of Smithtown School Age Child Care
Medication Authorization Form For Administration of Medication**

Name of Child: _____ Name of School: _____

Child's Date of Birth: _____ Address: _____

Diagnosis: Asthma

Medication:

Instructions:

=====

Self Medication Release Form

I, hereby, request that my child, _____ be given the medication above as prescribed by the physician. I, the parent or guardian authorize the School Age Child Care Staff to provide my child with the medication and agree that we will not hold liable any member of the School Age Child Care Staff or an individual of official capacity who is directed by us to provide the child the said medication.

It is my, (parent's) responsibility to provide the School Age Child Care Staff with inhalers in the original containers with the child's name on the label. I, the parent will ensure that the inhaler is up to date and not expired. I understand that my child/children are not able to attend the program if medication is expired or not in the original container.

Parent/Guardian Signature

Date

The above signature is valid for one-year from date signed.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
MEDICATION CONSENT FORM
CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? <i>(For example, did the licensed authorized prescriber write 12pm?)</i> <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the child day care program is to administer the medication <i>(i.e.: 12 pm)</i> : _____	
20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to <i>(child's name)</i> : _____	
21. Parent's Name <i>(please print)</i> : _____	22. Date Authorized: _____
23. Parent's Signature: X	

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

24. Program Name: _____	25. Facility ID Number: _____	26. Program Telephone Number: _____
27. I have verified that (#1 - #23) and if applicable, (#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.		
28. Staff's Name <i>(please print)</i> : _____	29. Date Received from Parent: _____	
30. Staff Signature: X		

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

31. I, parent, request that the medication indicated on this consent form be discontinued on _____ (Date) Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
32. Parent Signature: X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
34. 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 you are ordering the change in the administration of the prescription to take place. DATE: _____ By completing this section, the day care program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
35. Licensed Authorized Prescriber's Signature: X

