**MEDICATION POLICY**

* **Prescription Medications:** must have a current pharmacist’s label that includes the child’s full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
* **Non-prescription Children’s Medication:** can be administered for up to ***three consecutive days*** according to the manufacturer’s instructions with written authorization from the parent/guardian Written authorization from the child’s medical provider is required to continue use beyond the three consecutive days.
* **Non-prescription Topical Children’s Ointments:** can be applied with authorization from the parent/guardian according to the manufacturer’s instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.
* **Non-prescription Topical Children’s Ointments:** can be applied to **open, oozing sores** for up to ***three consecutive days*** according to the manufacturer’s instructions with written authorization from the parent/guardian. This includes diaper cream, sunscreen, insect repellant and other non- medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children. Written authorization from the child’s medical provider is required to continue use beyond the three consecutive days or if the condition worsens.
* **As Needed Children’s Medications:** require written authorization from the child’s medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.
* **Medications for Chronic Illnesses**: require a written order from the child’s medical provider for a period not to exceed ***one year***.
* **Homeopathic or Herbal Medications:** require written authorization signed by the parent/guardian and the child’s medical provider including reason, dosage, times of administration and start date and end date,

Additionally, please note the following:

* + The label will suffice as the medical provider’s authorization; however, if the pharmacist’s label **does not** provide all the necessary information to administer the medication to the child, a written order from the child’s medical provider will be required before the medication can be administered.
  + When a child is on a new medication, the first dose should be given to the child at home so the parents/guardians can check for any side effects from the medication.
  + All once a day medications and vitamins should be administered at home.
  + If while taking a medication, your child’s dosage should change, a new Authorization for Administration of Medication form will be required. If this is a prescription medication, this will also require an updated prescription or note from your child’s medical provider.
* Medication should not be provided in a child’s bottle. If the child is not feeding well, he or she may not get all the medication necessary into his or her system. Further, bottle-feeding times may not correspond with the appropriate medication administration schedule.
* Fever reducing medications such as acetaminophen cannot be administered by staff or parents/guardians so that a child can remain at the Center. The Center can administer fever- reducing medicines, at the parent/guardian’s request (if we have a note to administer fever- reducing medication on an as needed basis) to a child while he or she awaits the parent/guardian’s arrival, if written authorization from the parent/guardian and/or medical provider has been provided. The child cannot be readmitted to the Center until he or she is fever free for at least 24 hours and has no other symptoms.
* Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child’s medical provider for a period not to exceed ***seven consecutive days***.
* All medications must be provided in the original container, labeled with the child’s full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.
* A prescribed medication or an Authorization for Administration of Medication written and signed by the parent/guardian or who is also a physician is **not** acceptable. All prescribed medications and written authorizations for both prescription and non-prescription medications must originate from the child’s medical provider.

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

**MEDICATION TYPE:**❒**PRESCRIPTION** ❒**NON-PRESCRIPTION** ❒**TOPICAL OINTMENT**

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Bright Horizons agents to administer the following medication to my child:

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Prescription Medications:** must have a current pharmacist’s label that includes the child’s full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
* **Non-prescription Children’s Medication:** can be administered for up to ***three consecutive days*** according to the manufacturer’s instructions with written authorization from the parent/guardian Written authorization from the child’s medical provider is required to continue use beyond the three consecutive days.
* **Non-prescription Topical Children’s Ointments:** can be applied with authorization from the parent/guardian according to the manufacturer’s instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant designated for use for children.
* **Non-prescription Topical Children’s Ointments:** can be applied to **open, oozing sores** for up to ***three consecutive days*** according to the manufacturer’s instructions with written authorization from the parent. Written authorization from the child’s medical provider is required to continue use beyond the three consecutive days or if the condition worsens.
* **As Needed Children’s Medications:** require written authorization from the child’s medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.
* **Medications for Chronic Illnesses**: require a written order from the child’s medical provider for a period not to exceed ***one year***.

**Note:** Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child’s medical provider for a period not to exceed ***seven consecutive days***.

**Note:** All medications must be provided in the original container, labeled with the child’s full name and any medication spoon/device to administer the medication must be provided. Non prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Bright Horizons Children’s Centers LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

|  |  |
| --- | --- |
| Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Administration Route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication Storage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Six Rights of Medication**  **1. Verification that the *right* child receives**  **2. The *right* medication 3. In the *right* dose 4. At the *right* time 5. By the *right* method 6. *And the right* documentation is completed** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Side Effects: | | | | |
| Dosage: | | | | |
| Times of Administration: | Times of Administration: | Times of Administration: | | Times of Administration: |
| Start Date: | | End Date: | | |
| Physician’s Name: | | Physician’s Number: | | |
| Physician’s Signature: | | | | |
| Parent/Guardian Signature: | | | Date: | |

Individual Health Plan for Children with Allergies

*This form is only required for children who have mild to severe allergies that require medication to be administered if exposed to the allergen. If your child does not have any allergies, you and your child’s physician do not need to complete this form.*

|  |  |
| --- | --- |
| Child’s Name: | DOB: |
| Parent/Guardian Name: | Phone: |
| Physician’s Name: | Phone: |
| ALLERGEN | TREATMENT/SUBSCRIPTION |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**If the child is exposed to an allergen, watch for the following signs of a *mild* allergic reaction:**

⃞Hives ⃞Lightheadedness ⃞Red, swollen or itchy eyes ⃞Flushing ⃞Nausea/vomiting ⃞Tingling  
⃞Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the child is exposed to an allergen, watch for the following signs of a *severe* allergic reaction:**

⃞Lips/tongue swelling ⃞Tightness in chest or throat (child may complain of a lump in the throat or a scratchy throat)

⃞Wheezing/ difficulty breathing

⃞Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication should be administered at the following signs/severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescribed Medications/Dosage\*:  
Epinephrine** (brand and dose): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Antihistamine** (brand and dose): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other** (e.g., inhaler-bronchodilator if asthmatic): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Actions to be taken for a *Mild* Allergic Reaction**

⃞ Stay calm and do not leave the child unattended

⃞ Medication Administration

* Wash your hands
* Shake the bottle; measure the correct amount of medication using an approved medication spoon

or medication medicine cup

* Follow Medication Administration Procedures using the Medication Administration Log
* Observe the child for relief of symptoms
* Wash the child’s hands and yours with soap and water
* Offer cool compress to skin areas that are irritated

⃞ Notify the child’s parents

⃞ Notify a member of the Administrative Team  
⃞ Document the administration of the medication on the Administration of Medication Log  
⃞ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Actions to be taken for a *Severe* Allergic Reaction**

⃞ Stay calm and do not leave the child unattended.

⃞ Have someone call 911. Be sure to tell the dispatcher that the child is receiving an EpiPen.

⃞ Medication Administration (EpiPen)

* Remove the protector cap
* Hold the child’s thigh tightly and administer to the side of the thigh area. An EpiPen can be administered through clothing. Ask for assistance to help hold the child, if necessary.
* Press the injector to the thigh firmly and hold in place for 10 seconds.
* Remove the EpiPen and discard in a Sharp container, if available, or provide to the Emergency
* Response Personnel when they arrive for proper disposal.
* Note the time you administered the EpiPen to the child.
* Stay with the child and monitor his/her condition.

⃞ Notify the child’s parent(s)  
⃞ Notify a member of the Administration Team  
⃞ Document the administration of the medication on the Administration of Medication Log  
⃞ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Physician Signature: | Date: |
| Director/Principal: | Date: |

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a note from the child’s physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s); or be exposed to the item(s); nor can we add an item(s) or change a medication without a note from the child’s physician.

I understand that NEST requires the most up to date information regarding my child’s allergy. I also understand that for the safety of my child, my child’s photograph and allergy information will be posted in the classrooms and kitchen on the Allergy Awareness Chart.

|  |  |  |
| --- | --- | --- |
| Parent/Guardian Signature: | | Date: |
| Child’s Name: | | |
| Physician’s Name: | Physician’s Signature: | |

**Allergy Information Signature Form**

**Allergy Deletion**

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a note from the child’s physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s); or be exposed to the item(s); nor can we add an item(s) or change a medication without a note from the child’s physician.

**Allergy Posting**

I understand that Nest requires the most up to date information regarding my child’s allergy. I also understand that for the safety of my child, my child’s photograph and allergy information will be posted in the classrooms and kitchen on the Allergy Awareness Chart.

|  |  |
| --- | --- |
| Parent/Guardian Signature: | Date: |

Medication Dispensing Checklist

*This form is only required for children who have mild to severe allergies that require medication to be administered if exposed to the allergen. If your child does not have any allergies, you and your child’s physician do not need to complete this form.*

|  |  |
| --- | --- |
| Child’s Name: | DOB: |
| Parent/Guardian Name: | Teacher Name: |
| Name of Medication: | |
| Condition for which the Medication is Needed: | |

Please Check Yes or No to the following:

1. Is the Parental Consent for Administering Medication signed? ☐ Yes ☐ No

2. Is the prescription in the original container? ☐ Yes ☐ No

3. Is the Child’s Name on the container? ☐ Yes ☐ No

4. Is the expiration date on the medication current? ☐ Yes ☐ No

|  |  |
| --- | --- |
| Parent/Guardian Signature: | Date: |
| Health Specialist Signature: | Date: |