HEALTHY FUTURES

Improving Health Outcomes for Young Children

Medication Administration in Early Education and Child Care Settings

PARTICIPANT'S MANUAL

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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The recommendations in this curriculum do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Note: Brand names are for your information only. The AAP does not recommend any specific brand of drugs or products.

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HEALTHY FUTURES
Improving Health Outcomes for Young Children

Medication Administration in Early Education and Child Care Settings

PARTICIPANT'S MANUAL

Table of Contents

Introduction

The Healthy Futures: Improving Health Outcomes for Young Children, Medication Administration Curriculum has been made available by the American Academy of Pediatrics (AAP) Early Education and Child Care Initiatives.

The Medication Administration Curriculum is a collaborative effort of health care and early education and child care professionals from the AAP, Child Care Bureau State Administrators, Early Childhood Comprehensive Systems, Family Voices, National Association of Child Care Resource and Referral Agencies, National Association for the Education of Young Children, National Association of Pediatric Nurse Practitioners, National Child Care Information and Technical Assistance Center, National Resource Center for Health and Safety in Child Care and Early Education, National Training Institute for Child Care Health Consultants, and the Office of Head Start.

Beginning in October 2008, a Project Advisory Group, led by Elaine Donoghue, MD, FAAP, Stephanie Nelson, MS, CHES, and Deborah Mullen, Captus Communications, was developed. This group of more than 15 health care and early education and child care professionals was divided into 3 subgroups: a Content Work Group, a State-specific Issues Work Group, and an Implementation Work Group.

The Content Work Group reviewed the current resources available from state initiatives and, with permission, drew from their content and format for this curriculum. Initiatives from Colorado, New Jersey, North Carolina, and West Virginia were particularly helpful in the development of the Healthy Futures Medication Administration Curriculum.

The State-specific Issues Work Group reviewed state-specific regulations, Head Start Performance Standards, and National Association for the Education of Young Children Accreditation Standards and reported to the Content Work Group their findings and the impact on the Healthy Futures Medication Administration Curriculum.

The Implementation Work Group developed strategies to assist the AAP Chapter Child Care Contacts in how to facilitate the Healthy Futures Medication Administration Curriculum throughout their states. The group also looked at strategies to incorporate state-specific information.

The Healthy Futures Medication Administration Curriculum went through extensive review through the AAP, specifically, the Board of Directors; Committee on Early Childhood, Adoption, and Dependent Care; Committee on Medical Liability and Risk Management; Council on Community Pediatrics; Council on School Health; Medical Home Implementation Project Advisory Committee; Section on Early Education and Child Care; Section on Allergy and Immunology; and the Section on Pediatric Pulmonology.

Optimal instructors for this course include Child Care Health Consultants, pediatricians, or other licensed health care professionals with experience in child care settings.

MODULE 1
Background

- Introduction and reasons to give medication
- ADA, IDEA, state regulations
- Responsibility Triangle
- Types of medication





Medication Administration in Early Education and Child Care Settings

Sources

- **Colorado:** Guidelines for Medication Administration: An Instructional Program for Training Unlicensed Personnel to Give Medication in Out-of-Home Child Care, Schools, and Camp Settings, Fifth Edition, 2008, developed by Healthy Child Care Colorado
- **New Jersey:** Medication Administration in Child Care developed by Healthy Child Care New Jersey
- **North Carolina:** Medication Administration in Child Care in North Carolina developed by the Quality Enhancement Project for Infants and Toddlers, with funding from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill
- **West Virginia:** Medication Administration: An Instructional Program for Teaching Non-Medical Personnel to Give Medication in Child Care Centers in West Virginia developed by Healthy Child Care West Virginia and the West Virginia Department of Health and Human Services

Curriculum Objectives

1. Identify different types of medication, why medication is given, and how it is given
2. Improve medication storage, preparation, and administration techniques
3. Support good documentation of medication administration
4. Recognize and respond to adverse reactions to medication
5. Develop appropriate policies about medication administration and implement them

Disclaimer

- This curriculum provides education for personnel in the child care setting who give medication to children but are not licensed health care professionals
- It is not a substitute for written policy and professional medical guidance
- It is not certification of competency
- Actual care must be based on the child's clinical presentation, the health care professional's orders, parental guidance, personnel experience and training, and facility policy
- Each program must review state laws, regulations, and resources, and adapt accordingly

What Is *Covered* in This Instructional Program

- Typical and routine medications for short-term use
- Medications taken on a regular basis for chronic health conditions
- Emergency medications

What Is *Not Covered* in This Instructional Program

- Special medications like injectable or rectal medication
- Clinical explanation of the conditions being treated (such as asthma)
- Principles of caring for children with special needs
- Dietary issues such as restrictions or supplements for allergies or other medical conditions

These are important topics that are beyond the scope of today's program

MODULE 1
Background

- Introduction and reasons to give medication
- ADA, IDEA, state regulations
- Responsibility Triangle
- Types of medication

Why Give Medication in Child Care?

What do you think?

Why are Medications Given at All?

- Prevent illness: Barrier cream to prevent diaper rash
- Relieve symptoms: Fever reducing medications
- Control or cure health problems:
  - *Short term:* Antifungal cream to treat a fungal diaper rash
  - *Emergency:* Albuterol for wheezing
  - *Long term:* Anti-seizure medications

Why Give Medication in Child Care?

- To maintain the health of the child
- To allow a child who is not acutely ill to attend the program
- To comply with laws, regulations, and best practice

When Should Medication Be Given?

- Medication should be given at home by parents/guardians, if possible
- Prescribers should try to minimize the number of doses given at a child care facility

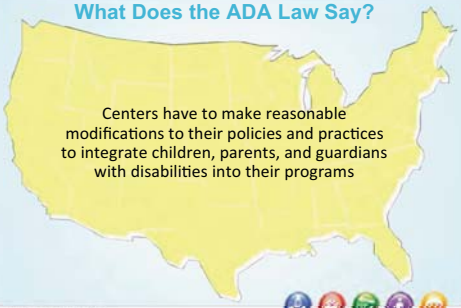
State Licensing Regulations

- Seek to ensure basic health and safety parameters
- Are minimal standards for a licensed program to operate legally

Best Practice Standards

- Are optimal standards to strive towards
- Publications, such as *Caring for Our Children*, attempt to set best practice standards

What Does the ADA Law Say?

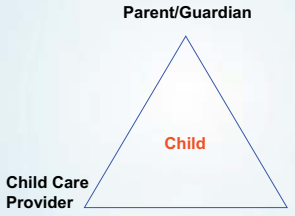


Centers have to make reasonable modifications to their policies and practices to integrate children, parents, and guardians with disabilities into their programs

How About Liability?

- Liability:
  - something for which one is liable
  - an obligation, responsibility, or debt
- Child care providers are more likely to administer medication than to perform CPR in the child care setting
- Review liability insurance for any stipulations related to medication administration

Responsibility Triangle



Parent or Guardian Responsibilities

- Regular checkups and up-to-date immunizations
- Complete communication about child's symptoms and health status
- Consulting with their child's health care professional about diagnosis and care
- Compliance with medication policies and completion of forms
- Communication with health care professionals about the child care setting (environment, capabilities of staff, hours that the child attends)

Parent/Guardian Responsibilities, continued

- Asking the health care professional about whether medication can be given at home and NOT in child care
- Providing properly labeled medication and providing appropriate measuring devices
- Providing up-to-date emergency contact phone numbers
- Promptly picking up their child when notified of illness
- Arranging for back-up care
- Working constructively with child care providers to determine when it is appropriate to care for their child during mild illness

Child Care Provider Responsibilities

- Careful, periodic monitoring of health records (history, physical, immunizations, screenings)
- Practicing daily health checks
- Having and communicating clear policies on medication, exclusion, and re-admittance
- Maintaining good hygiene practices
- Promptly communicating with parents or guardians about their child's symptoms
- Using available resources for health consultation
- Obtaining training about medication administration

Health Care Professional Responsibilities

- Complete all child care health forms legibly
- Discuss medication needs with parent or guardian and if needed, with child care providers, if parental permission is obtained
- Adapt medication schedules to meet the needs of children in child care and limit the number of doses that need to be given in child care
- Provide guidance and education as requested
- Promote disease prevention and good health practices
- Be accessible to child care staff for questions and concerns about their patients, with parental permission

Child Care Health Consultant

- A trained health care professional who provides consultation and technical assistance on health issues in child care
- Child care facilities can request consultation from professionals with special expertise

Types of Medication

- Prescription (Rx), over-the-counter (OTC), and non-traditional
- Brand name and generic
- Oral, topical, and inhaled, etc

Prescription Medication

- Can only be prescribed by an authorized health care professional
- Are dispensed by a pharmacist
- Are considered “controlled substances” if they can be dangerous or addictive
  - Controlled substances have special rules
- “Sample” medication must be properly labeled

OTC Medication

- Can be purchased without a prescription
- Vitamins
- Homeopathic medication
- Herbal medication
- Sun screen, insect repellant, and non-medicated diaper cream often have different regulations
  - Check your state regulations

Common OTC Medication

- Fever reducer or pain reliever
- Antihistamines
- Mild cortisone cream
- Cough syrups and cold remedies
- Nose drops
- Medications used for common gastrointestinal problems
- *Many OTC medications do not have dosing information for children under the age of 24 months*

Brand Name and Generic Medications

- Both prescription and OTC medications come as
  - Brand name
  - Generic
- This creates an opportunity for mistakes and confusion
  - Names that are difficult to remember and to say
  - Available under several names
  - Sound alike names
    - Zantac® (reduces stomach acid) and Zyrtec® (antihistamine)
    - Bacitracin® (antibiotic cream) and Bactrim® (oral antibiotic)

Forms of Medication Video

Forms of Medication: Oral

Tablets

- *Coated and uncoated:* Swallow whole
- *Chewable:* Must be chewed, not swallowed whole
- *Scored:* May be cut in half

Capsules

- *Swallow:* Do not crush or chew
- *Sprinkle:* Do so only with health care professional instruction

Forms of Medication: Oral, continued

Liquid

- *Suspensions:* Undissolved medications in liquid
  - Must be shaken prior to pouring
  - Usually needs refrigeration
- *Syrups:* Sweetened liquids that contain dissolved medication
- *Elixirs:* Sweetened liquids in a dilute alcohol base which contain dissolved medication

Forms of Medication: Oral, continued

Other oral medications

- Sublingual
  - Placed under the tongue
- Melting strips and tablets
  - Absorbed directly in the mouth
- Gums and gels

Forms of Medication: Topical

- *Drops:* Eyes, ears, or nose
- *Sprays:* Nose or throat
- *Patches*

Forms of Medication: Topical, continued

- Creams, Ointments, and Sprays for external application of medication for rash or skin problems
  - Prescription versus OTC
  - Preventative versus treatment

Forms of Medication: Inhalation

- *Inhalation:* Breathing or inhaling a drug into the respiratory tract
- Methods include:
  - *Inhaler:* Metered Dose Inhalant (MDI) or HFA (hydrofluoroalkane), "puffer"
  - *Nebulizer:* Mist created by a machine
  - *Powders:* Turbohalers, discs
  - *Spray:* Nasal, throat

Forms of Medication: Injection

- EpiPen® and EpiPen® Jr
- Glucagon
- Insulin
- Need special training and will not be covered in this program


HEALTHY FUTURES
Medication Administration Curriculum - Module 1
Forms of Medication: Suppository
• Suppositories are inserted into the rectum
• Need special training and will not be covered in this program
• States vary, so check your local laws and regulations
American Academy of Pediatrics

Name State Date

Medication Administration in Child Care Pre-test

Instructions: Circle the letter of the choice that best completes the statement or answers the question.

MODULE 1

1. The Americans with Disabilities Act states that a reasonable accommodation includes:

a. Giving medication ONLY if the child care facility receives federal funding
b. Giving medication to children with ongoing special health needs
c. Admitting a child with special health care needs but not giving medication
d. None of the above

2. Medication available without a health care professional's note or pharmacy label is called:

a. Prescription medication
b. Over-the-counter (OTC) medication
c. Non-toxic medication
d. None of the above

3. Matching: In the blanks next to each definition below, enter the number of the word that corresponds to the definition.

Word List		Definitions
1. Oral	_____	Medication that is administered by breathing it into the respiratory system (for example, a mist or spray medication)
2. Topical	_____	Medication in lotion, cream, ointment, spray, or other form for external application for skin or other medical problems
3. Inhalation	_____	Form of medication that is inserted into the rectum
4. Injectable	_____	Medication that is put into the mouth such as tablets, capsules, and liquid medication
5. Suppository	_____	Medication that is put into the body with a needle or other device that rapidly puts the medication through the skin surface, such as the EpiPen®, Glucagon®, and insulin.

Module 2

4. **Your facility policy should include all of the following:**
   a. Who will administer medication and who the alternate person will be
   b. What medication will be given
   c. Where and how medication will be stored
   d. Procedure for medication error or incident
   e. All of the above

5. **A mother brings in some chewable tablets that she took from a bottle of medication that she says her daughter's health care professional prescribed the day before. The mother is keeping the main supply of the medication at home. She fills out the program forms to give permission to the staff to give the medication at noon to her child. What is the most appropriate thing for the child care provider to do?**
   a. Call the health care professional immediately to see if it is okay to give the medication
   b. Give the medication to the child if it looks/smells okay
   c. Refuse to give the medication
   d. Don't know

6. **When receiving a medication you should:**
   a. Match the label with permissions and instructions
   b. Ask the parent/guardian about successful techniques that he has used to administer the medication
   c. Ask the parent/guardian about when the medication was last administered
   d. All of the above

7. **A guardian brings you medication for her child. After receiving the medication, your next step should be to:**
   a. Sort the medication for ease of delivery
   b. Log in medication and store it
   c. Administer the medication within the next 3 hours
   d. Don't know

8. **All of the following are steps in the process of receiving medications EXCEPT:**
   a. Match the label with the instructions
   b. Check if container is labeled child-resistant
   c. Check expiration date
   d. Ensure that the child receives a dose that same day

Name State Date

Module 3

9. Ways to tell if you have the Right child include all of the following EXCEPT:

a. Knowing the child from your experience
b. Asking the child if she is the name that appears on the label
c. Having a photo of the child attached to the medication administration paperwork
d. Having another staff member who is familiar with the child verify her identity

10. Administering the Right dose of medication involves all of the following EXCEPT:

a. Checking the label and the permission form to see if they match.
b. Using a measuring device
c. Verifying the dose with the child
d. Checking the measuring device at eye level

11. Which of the following is an example of an "as needed medication"?

a. Tylenol® for fever
b. Albuterol® for wheezing
c. Amoxicillin for ear infection
d. A and B
e. All of the above

12. A child refuses to take her medication. In order to get the child to comply, you consider mixing the medication with her favorite beverage. Before doing so you should:

a. Split the medication into 2 doses to ensure that the child takes her full dosage
b. Check with the health care professional or pharmacist before mixing medications with food or beverages
c. Give the child a small portion of the beverage prior to mixing the medication into it
d. None of the above

13. A young toddler in your care is refusing to take a dose of antibiotic. You should:

a. Mix it in the child's bottle
b. Hold his nose until he opens his mouth
c. Refuse to give the child the medication
d. Give the child the choice of what drink he wants after taking the medication

Name State Date

Module 4

14. Please read the scenario and enter the information into the medication log below.

Scenario: Today, you give Nick one 125 mg capsule of Depakote® sprinkles at 12:00 PM.

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Name State Date

Module 5

15. Upset stomach, diarrhea, dry mouth, changes in mood, and drowsiness after taking a medication are all examples of:

a. Effective medication
b. Medication errors
c. Side effects
d. Overdose of medication

16. When calling Poison Control, you should have which of the following information available?

a. The medication container
b. The child's current weight
c. The child's Emergency Contact Form
d. All of the above
e. None of the above

17. In which of the following situations should Poison Control be called:

a. The child refuses to take his medication
b. You give the wrong medication to a child
c. You give a medication to the wrong child
d. B and C

18. A child takes his medication in his mouth and then spits it out. What actions should be performed?

a. Notify the parent/guardian
b. Repeat the dose
c. Fill out a medication incident report
d. A and C
e. All of the above

19. It is 2:00 PM and you realize that you forgot to give a dose of medication that was due at 12:00 PM. The first thing you should do is:

a. Give the dose right away
b. Document the missed dose and notify the parent
c. Contact the child's doctor
d. Contact the pharmacist's advice

Name State Date

AMERICANS WITH DISABILITIES ACT

COMMONLY ASKED QUESTIONS RELATED TO GIVING MEDICINE IN CHILD CARE

The Americans with Disabilities Act (ADA), passed July 26, 1990 as Public Law 101-336 (42 U.S.C. Sec. 12101 *et seq.*), became effective on January 26, 1992. The ADA requires that child care provider/directors not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parent/guardians with disabilities with an equal opportunity to participate in child care programs and services. Child care facilities must make reasonable modifications to their policies and practices, such as giving medicine, to integrate children with disabilities.

1. **Q: Does the Americans with Disabilities Act -- or "ADA" -- apply to child care centers? What about family child care homes?**

A: Yes. Almost all child care facilities, even small, home-based centers regardless of size or number of employees, must comply with title III of the ADA. Child care services provided by government agencies must comply with title II. The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

2. **Q: Our facility has a policy that we will not give medication to any child. Can I refuse to give medication to a child with a disability?**

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. Disabilities include any physical or mental impairment that substantially limits one or more major life activities including asthma, diabetes, seizure disorders, or attention deficit hyperactivity disorder (ADHD).

3. **Q: What about children who have severe, sometimes life-threatening allergies to bee stings or certain foods? Do we have to take them?**

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A child care facility needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called "epinephrine" that will be provided in advance by the child's parents or guardians.

4. **Q: What about children with diabetes? Do we have to admit them to our program? If we do, do we have to test their blood sugar levels?**

A: Generally, yes. Children with diabetes should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child's blood sugar – or "blood glucose". The child's parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

5. **Q: What about children with asthma? Do we have to admit them to our program?**

A: Generally, yes. Children with asthma should not be excluded from the program on the basis of their medical condition. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for asthma care.

6. **Q: Are there any reference books or video tapes that might help me further understand the obligations of child care providers under title III?**

A: Yes, the Arc published *All Kids Count: Child Care and the ADA*, which addresses the ADA's obligations of child care providers. Copies are available by calling **1-800-433-5255.** For general information child care providers may call the Department of Justice Information Line at **1-800-514-0301.**

Source: The ADA Home Page: www.usdoj.gov/crt/ada/adahom1.htm

U.S. Department of Justice

Civil Rights Division

Disability Rights Section

Child Care Centers and the Americans with Disabilities Act

Privately-run child care centers - like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks must comply with title III of the Americans with Disabilities Act (ADA). Child care services provided by State and local government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

COMMONLY ASKED QUESTIONS ABOUT CHILD CARE CENTERS AND THE AMERICANS WITH DISABILITIES ACT

Coverage

1. Q: Does the Americans with Disabilities Act -- or "ADA" -- apply to child care centers?

A: Yes. Privately-run child care centers -- like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks -- must comply with title III of the ADA. Child care services provided by government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

A child care center's employment practices are covered by other parts of the ADA and are not addressed here. For more information about the ADA and employment practices, please call the Equal Employment Opportunity Commission (see question 30).

2. Q: Which child care centers are covered by title III?

A: Almost all child care providers, regardless of size or number of employees, must comply with title III of the ADA. Even small, home-based centers that may not have to follow some State laws are covered by title III.

The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

Private child care centers that are operating on the premises of a religious organization, however, are generally **not** exempt from title III. Where such areas are leased by a child care program not controlled or operated by the religious organization, title III applies to the child care program but not the religious organization. For example, if a private child care program is operated out of a church, pays rent to the church, and has no other connection to the church, the program has to comply with title III but the church does not.

General Information

3. Q: What are the basic requirements of title III?

A: The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care center's programs and services. Specifically:

- Centers cannot exclude children with disabilities from their programs unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.

- Centers have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.

- Centers must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.

- Centers must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

4. Q: How do I decide whether a child with a disability belongs in my program?

A: Child care centers cannot just assume that a child's disabilities are too severe for the child to be integrated successfully into the center's child care program. The center must make an *individualized assessment* about whether it can meet the particular needs of the child without fundamentally altering its program. In making this assessment, the caregiver must not react to unfounded preconceptions or stereotypes about what children with disabilities can or cannot do, or how much assistance they may require. Instead, the caregiver should talk to the parents or guardians and any other professionals (such as educators or health care professionals) who work with the child in other contexts. Providers are often surprised at how simple it is to include children with disabilities in their mainstream programs.

Child care centers that are accepting new children are not required to accept children who would pose a *direct threat* (see question 8) or whose presence or necessary care would *fundamentally alter* the nature of the child care program.

. Q: y insurance company says it will raise our rates if we accept children with disabilities. o I still have to admit them into my program?

A: Yes. Higher insurance rates are not a valid reason for excluding children with disabilities from a child care program. The extra cost should be treated as overhead and divided equally among all paying customers.

. Q: ur center is full and we have a waiting list. o we have to accept children with disabilities ahead of others?

A: No. Title III does not require providers to take children with disabilities out of turn.

. Q: ur center speciali es in group child care. an we re ect a child ust because she needs individuali ed attention?

A: No. Most children will need individualized attention occasionally. If a child who needs one-to-one attention due to a disability can be integrated without fundamentally altering a child care program, the child cannot be excluded solely because the child needs one-to-one care.

For instance, if a child with Down Syndrome and significant mental retardation applies for admission and needs one-to-one care to benefit from a child care program, and a personal assistant will be provided at no cost to the child care center (usually by the parents or though a government program), the child cannot be excluded from the program solely because of the need for one-to-one care. Any modifications necessary to integrate such a child must be made if they are reasonable and would not fundamentally alter the program. This is not to suggest that all children with Down Syndrome need one-to-one care or must be accompanied by a personal assistant in order to be successfully integrated into a mainstream child care program. As in other cases, an *individualized assessment* is required. But the ADA generally does not require centers to hire additional staff or provide constant one-to-one supervision of a particular child with a disability.

. Q: What about children whose presence is dangerous to others? o we have to ta e them too?

A: No. Children who pose a *direct threat* -- a substantial risk of serious harm to the health and safety of others -- do not have to be admitted into a program. The determination that a child poses a direct threat may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an *individualized assessment* that considers the particular activity and the actual abilities and disabilities of the individual.

In order to find out whether a child has a medical condition that poses a significant health threat to others, child care providers may ask all applicants whether a child has any diseases that are communicable through the types of incidental contact expected to occur in child care settings. Providers may also inquire about specific conditions, such as active infectious tuberculosis, that in fact pose a direct threat.

The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page.

www.usdo .gov crt ada adahom .htm

The Department of Justice also operates an ADA Electronic Bulletin Board, on which a wide variety of information and documents are available.

2 2 4 3 (by computer modem)

There are ten regional Disability and Business Technical Assistance Centers, or DBTAC's, that are funded by the Department of Education to provide technical assistance under the ADA. One toll-free number connects to the center in your region.

4 4232 (voice & TDD)

The Access Board offers technical assistance on the ADA Accessibility Guidelines.

2 22 3 (voice)

3 2 22 (TDD)

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2 2 2 2 44

ource: http: www.usdo .gov crt ada childq a.htm

ote: eproduction of this document is encouraged.

10/97

. Q: ne of the children in my center hits and bites other children. His parents are now saying that I can t e pel him because his bad behavior is due to a disability. What can I do?

A: The first thing the provider should do is try to work with the parents to see if there are reasonable ways of curbing the child's bad behavior. He may need extra naps, "time out," or changes in his diet or medication. If reasonable efforts have been made and the child continues to bite and hit children or staff, he may be expelled from the program even if he has a disability. The ADA does not require providers to take any action that would pose a *direct threat* -- a substantial risk of serious harm -- to the health or safety of others. Centers should not make assumptions, however, about how a child with a disability is likely to behave based on their past experiences with other children with disabilities. Each situation must be considered individually.

. Q: ne of the children in my center has parents who are deaf. I need to have a long discussion with them about their child s behavior and development. o I have to provide a sign language interpreter for the meeting?

A: It depends. Child care centers must provide effective communication to the customers they serve, including parents and guardians with disabilities, unless doing so poses an undue burden. The person with a disability should be consulted about what types of auxiliary aids and services will be necessary in a particular context, given the complexity, duration, and nature of the communication, as well as the person's communication skills and history. Different types of *au iliary aids and services* may be required for lengthy parent-teacher conferences than will normally be required for the types of incidental day-to-day communication that take place when children are dropped off or picked up from child care. As with other actions required by the ADA, providers cannot impose the cost of a qualified sign language interpreter or other auxiliary aid or service on the parent or guardian.

A particular auxiliary aid or service is not required by title III if it would pose an *undue burden*, that is, a significant difficulty or expense, relative to the center or parent company's resources.

. Q: We have a no pets policy. o I have to allow a child with a disability to bring a service animal such as a seeing eye dog?

A: Yes. A service animal is **not** a pet. The ADA requires you to modify your "no pets" policy to allow the use of a service animal by a person with a disability. This does not mean that you must abandon your "no pets" policy altogether, but simply that you must make an exception to your general rule for service animals.

2. Q: If an older child has delayed speech or developmental disabilities can we place that child in the infant or toddler room?

A: Generally, no. Under most circumstances, children with disabilities must be placed in their age-appropriate classroom, unless the parents or guardians agree otherwise.

3. Q: an I charge the parents for special services provided to a child with a disability provided that the charges are reasonable?

A: It depends. If the service is required by the ADA, you cannot impose a surcharge for it. It is only if you go beyond what is required by law that you can charge for those services. For instance, if a child requires complicated medical procedures that can only be done by licensed medical personnel, and the center does not normally have such personnel on staff, the center would not be required to provide the

medical services under the ADA. If the center chooses to go beyond its legal obligation and provide the services, it may charge the parents or guardians accordingly. On the other hand, if a center is asked to do simple procedures that are required by the ADA -- such as finger-prick blood glucose tests for children with diabetes (see question 20) -- it cannot charge the parents extra for those services. To help offset the costs of actions or services that are required by the ADA, including but not limited to architectural barrier removal, providing sign language interpreters, or purchasing adaptive equipment, some tax credits and deductions may be available (see question 24).

ersonal ervices

4. Q: ur center has a policy that we will not give medication to any child. an I refuse to give medication to a child with a disability?

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. While some state laws may differ, generally speaking, as long as reasonable care is used in following the doctors' and parents' or guardians written instructions about administering medication, centers should not be held liable for any resulting problems. Providers, parents, and guardians are urged to consult professionals in their state whenever liability questions arise.

. Q: We diaper young children but we have a policy that we will not accept children more than three years of age who need diapering. an we re ect children older than three who need diapering because of a disability?

A: Generally, no. Centers that provide personal services such as diapering or toileting assistance for young children must reasonably modify their policies and provide diapering services for older children who need it due to a disability. Generally speaking, centers that diaper infants should diaper older children with disabilities when they would not have to leave other children unattended to do so.

Centers must also provide diapering services to young children with disabilities who may need it more often than others their age.

Some children will need assistance in transferring to and from the toilet because of mobility or coordination problems. Centers should not consider this type of assistance to be a "personal service."

. Q: We do not normally diaper children of any age who are not toilet trained. o we still have to help older children who need diapering or toileting assistance due to a disability?

A: It depends. To determine when it is a reasonable modification to provide diapering for an older child who needs diapering because of a disability and a center does not normally provide diapering, the center should consider factors including, but not limited to, (1) whether other non-disabled children are young enough to need intermittent toileting assistance when, for instance, they have accidents; (2) whether providing toileting assistance or diapering on a regular basis would require a child care provider to leave other children unattended; and (3) whether the center would have to purchase diapering tables or other equipment.

If the program never provides toileting assistance to any child, however, then such a personal service would not be required for a child with a disability. Please keep in mind that even in these circumstances, the child could not be excluded from the program because he or she was not toilet trained if the center can make other arrangements, such as having a parent or personal assistant come and do the diapering.

Issues egarding pecific isabilities

. Q: an we e clude children with HI or AI from our program to protect other children and employees?

A: No. Centers cannot exclude a child solely because he has HIV or AIDS. According to the vast weight of scientific authority, HIV/AIDS cannot be easily transmitted during the types of incidental contact that take place in child care centers. Children with HIV or AIDS generally can be safely integrated into all activities of a child care program. Universal precautions, such as wearing latex gloves, should be used whenever caregivers come into contact with children's blood or bodily fluids, such as when they are cleansing and bandaging playground wounds. This applies to the care of all children, whether or not they are known to have disabilities.

. Q: ust we admit children with mental retardation and include them in all center activities?

A: Centers cannot generally exclude a child just because he or she has mental retardation. The center must take reasonable steps to integrate that child into every activity provided to others. If other children are included in group sings or on playground expeditions, children with disabilities should be included as well. Segregating children with disabilities is not acceptable under the ADA.

. Q: What about children who have severe sometimes life threatening allergies to bee stings or certain foods? o we have to ta e them?

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A center needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called "epinephrine" that will be provided in advance by the child's parents or guardians.

The Department of Justice's settlement agreement with La Petite Academy addresses this issue and others (see question 26).

2 . Q: What about children with diabetes? o we have to admit them to our program? If we do do we have to test their blood sugar levels?

A: Generally, yes. Children with diabetes can usually be integrated into a child care program without fundamentally altering it, so they should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child's blood sugar -- or "blood glucose" -- levels before lunch and whenever the child appears to be having certain easy-to-recognize symptoms of a low blood sugar incident. While the process may seem uncomfortable or even frightening to those unfamiliar with it, monitoring a child's blood sugar is easy to do with minimal training and takes only a minute or two. Once the caregiver has the blood sugar level, he or she must take whatever simple actions have been recommended by the child's parents or guardians and doctor, such as giving the child some fruit juice if the child's blood sugar level is low. The child's parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

The Department of Justice's settlement agreements with KinderCare and La Petite Academy address this issue and others (see question 26).

2 . Q: o we have to help children ta e off and put on their leg braces and provide similar types of assistance to children with mobility impairments?

A: Generally, yes. Some children with mobility impairments may need assistance in taking off and putting on leg or foot braces during the child care day. As long as doing so would not be so time consuming that other children would have to be left unattended, or so complicated that it can only done by licensed health care professionals, it would be a *reasonable modification* to provide such assistance.

The Department of Justice's settlement agreement with the Sunshine Child Center of Gillett, Wisconsin, addresses this issue and others (see question 26).

a ing the hild are acility Accessible

22. Q: How do I ma e my child care center s building playground and par ing lot accessible to people with disabilities?

A: Even if you do not have any disabled people in your program now, you have an ongoing obligation to remove barriers to access for people with disabilities. Existing privately-run child care centers must remove those architectural barriers that limit the participation of children with disabilities (or parents, guardians, or prospective customers with disabilities) if removing the barriers is *readily achievable*, that is, if the barrier removal can be easily accomplished and can be carried out without much difficulty or expense. Installing offset hinges to widen a door opening, installing grab bars in toilet stalls, or rearranging tables, chairs, and other furniture are all examples of barrier removal that might be undertaken to allow a child in a wheelchair to participate in a child care program. Centers run by government agencies must insure that their programs are accessible unless making changes imposes an undue burden; these changes will sometimes include changes to the facilities.

23. Q: We are going to build a new facility. What architectural standards do we have to follow to ma e sure that our facility is accessible to people with disabilities?

A: Newly constructed privately-run child care centers -- those designed and constructed for first occupancy after January 26, 1993 -- must be readily accessible to and usable by individuals with disabilities. This means that they must be built in strict compliance with the ADA Standards for Accessible Design. New centers run by government agencies must meet either the ADA Standards or the Uniform Federal Accessibility Standards.

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24. Q: Are there ta credits or deductions available to help offset the costs associated with complying with the A A?

A: To assist businesses in complying with the ADA, Section 44 of the IRS Code allows a tax credit for small businesses and Section 190 of the IRS Code allows a tax deduction for all businesses.

The tax credit is available to businesses that have total revenues of $1,000,000 or less in the previous tax year or 30 or fewer full-time employees. This credit can cover 50% of the eligible access expenditures in a year up to $10,250 (maximum credit of $5,000). The tax credit can be used to offset the cost of complying with the ADA, including, but not limited to, undertaking barrier removal and alterations to improve accessibility; provide sign language interpreters; and for purchasing certain adaptive equipment.

The tax deduction is available to all businesses with a maximum deduction of $15,000 per year. The tax deduction can be claimed for expenses incurred in barrier removal and alterations.

To order documents about the tax credit and tax deduction provisions, contact the Department of Justice's ADA Information Line (see question 30).

he epartment of ustice s nforcement fforts

2 . Q: What is the epartment of ustice s enforcement philosophy regarding title III of the A A?

A: Whenever the Department receives a complaint or is asked to join an on-going lawsuit, it first investigates the allegations and tries to resolve them through informal or formal settlements. The vast majority of complaints are resolved voluntarily through these efforts. If voluntary compliance is not forthcoming, the Department may have to litigate and seek injunctive relief, damages for aggrieved individuals, and civil penalties.

2 . Q: Has the nited tates entered into any settlement agreements involving child care centers?

A: The Department has resolved three matters through formal settlement agreements with the Sunshine Child Center, KinderCare Learning Centers, and La Petite Academy.

- In the first agreement, Sunshine Child Center in Gillett, Wisconsin, agreed to: (1) provide diapering services to children who, because of their disabilities, require diapering more often or at a later age than nondisabled children; (2) put on and remove the complainant's leg braces as necessary; (3) ensure that the complainant is not unnecessarily segregated from her age-appropriate classroom; (4) engage in readily achievable barrier removal to its existing facility; and (5) design and construct its new facility (planned independently of the Department's investigation) in a manner that is accessible to persons with disabilities.

- In 1996, the Department of Justice entered into a settlement agreement with KinderCare Learning Centers -- the largest chain of child care centers in the country -- under which KinderCare agreed to provide appropriate care for children with diabetes, including providing finger-prick blood glucose tests. In 1997, La Petite Academy -- the second-largest chain -- agreed to follow the same procedures.

- In its 1997 settlement agreement with the Department of Justice, La Petite Academy also agreed to keep epinephrine on hand to administer to children who have severe and possibly life-threatening allergy attacks due to exposure to certain foods or bee stings and to make changes to some of its programs so that children with cerebral palsy can participate.

The settlement agreements and their attachments, including a waiver of liability form and parent and physician authorization form, can be obtained by calling the Department's ADA Information Line or through the Internet (see question 30). Child care centers and parents or guardians should consult a lawyer in their home state to determine whether any changes need to be made before the documents are used.

2 . Q: Has the epartment of ustice ever sued a child care center for A A violations?

A: Yes. On June 30, 1997, the United States filed lawsuits against three child care providers for refusing to enroll a four-year-old child because he has HIV. See **nited tates v. Happy ime ay are enter**, (W.D. Wisc.); **nited tates v. iddie anch**, (W.D. Wisc.); and **nited tates v. A ursery Inc.** (W.D. Wisc.).

2 . Q: oes the nited tates ever participate in lawsuits brought by private citi ens?

A: Yes. The Department sometimes participates in private suits either by intervention or as *amicus curiae* -- "friend of the court." One suit in which the United States participated was brought by a disability rights group against KinderCare Learning Centers. The United States supported the plaintiff's position that KinderCare had to make its program accessible to a boy with multiple disabilities including mental retardation. The litigation resulted in KinderCare's agreement to develop a model policy to allow the child to attend one of its centers with a state-funded personal assistant.

Additional esources

2 . Q: Are there any reference boo s or video tapes that might help me further understand the obligations of child care providers under title III?

A: Through a grant from the Department of Justice, The Arc published ***All Kids Count: Child Care and the ADA***, which addresses the ADA's obligations of child care providers. Copies are available for a nominal fee by calling The Arc's National Headquarters in Arlington, Texas:

433 2 (voice)

(TDD)

Under a grant provided by the Department of Justice, Eastern Washington University (EWU) produced eight 5-7 minute videotapes and eight accompanying booklets on the ADA and child care providers. The videos cover different ADA issues related to child care and can be purchased as a set or individually by contacting the EWU at:

23 424 (voice)

: use relay service

3 . Q: I still have some general questions about the A A. Where can I get more information?

A: The Department of Justice operates an ADA Information Line. Information Specialists are available to answer general and technical questions during business hours on the weekdays. The Information Line also provides 24-hour automated service for ordering ADA materials and an automated fax back system that delivers technical assistance materials to fax machines or modems.

4 3 (voice)

4 3 3 (TDD)

MODULE 2
Preparation

- Forms
- Policies
- Confidentiality
- Receiving and storing medication
- Disposing of medication




MODULE 2

Preparation

- Forms
- Policies
- Confidentiality
- Receiving and storing medication
- Disposing of medication

What Forms Are Needed?

1. Child Health Assessment
   - May be called by many different names
   - Care Plan or Individual Health Plan if child has chronic or life-threatening condition
2. Medication Administration Packet
   - Authorization to Give Medicine
   - Receiving Medication
   - Medication Log
3. Emergency Contact Form (may be combined with other forms)
4. Health Care Professional's Order
   - Rx label can serve as the order

Child Health Assessment

A full health assessment:

- Physical examination results
- Immunization record
- Medical conditions
- Preventive health screenings, if required

Care Plans or Individualized Health Plans for Children with Special Health Care Needs

- The usual Child Health Assessment might not be detailed enough to allow the best care for the child
- The care plan should:
  - Be completed by a health care professional
  - Provide information about any ongoing or emergency medication
  - Outline modifications to:
    - diet
    - environment
    - activities

Medication Administration Packet: Authorization to Give Medicine

- To be completed by parent or guardian
- Child's Information
- Prescriber's Information
- Permission to Give Medication

Medication Administration Packet: Receiving Medication

- Checklist of steps to take to receive and safely store medication
- To be completed by child care staff
- Steps include:
  - checking labels and containers
  - ensuring that all forms are complete
  - questioning parent/guardian to gather necessary information

Medication Administration Packet: Medication Log

- To be completed by child care staff
- Should include the following:
  - Name of child
  - Medication
  - Day, time, dose, route, and staff signature
  - Comments and observations
  - Return or disposal of medication notation
- Prescription and OTC medication must all be logged

Emergency Contact Form

- How to contact the family
- Permission to speak with the health care professional regarding a specific child's health needs

Health Care Professional's Orders

- For prescription medication
  - Pharmacy label = order for prescription medication
- For OTC medication
  - Parent's instructions are okay in most states if it matches dose given on the medication label
- A written order from a health care professional is helpful and is required in some states
- A written order from a health care professional is essential if:
  - The child is under 24 months and the dose is not on the label
  - Parent instructions do not match the dose on the label
- Check state regulations for the length of time that a health care professional's order is valid.

Health Care Professional's Orders, continued

- "As needed" or "prn" orders should have specific information about what symptoms qualify as needing medication
- State regulations vary about telephone orders
  - Check your state regulations carefully
  - All telephone orders should be followed by written documentation

Health Care Professional's Orders, continued

Must be clear and specify:
- Child's first and last name
- Date of order
- Name of medication
- Amount (dose)
- Time, route, and frequency
- Signature of licensed health care professional
- Expiration date of medication

Might list:
- Reason for medication
- Possible side effects or adverse reactions, if any

Medication Policy: What It Should Include

A **written** policy should state:
- ***Who*** will give medication
- ***What*** medication will be given
- ***Where*** will medication be given and stored
- ***When*** medication will be given
- ***How*** confidentiality will be maintained
- ***What*** procedures and forms are to be used for permission and documentation
- ***What*** procedures are used when giving medication (5 Rights)
- ***What*** procedure should take place in the event of a medication error or incident

Policy: Who Will Give Medication?

- The policy should state:
  - Who is designated to give medication
  - Who will serve as the alternate if the designated person is unavailable
- The designated person should:
  - Have the qualifications for the task
  - Be relieved of other duties when administering medication
- Some states require formal performance evaluation of the designated medication administration staff by a health care professional

Policy: What Medications Will Be Given?

- The policy should say why medications are given and what types of medications are appropriate to give in child care
  - The policy should apply to prescription and OTC medications
  - Off-label, folk remedies should be limited
  - Homeopathic and herbal medications are only given with an order from an authorized health care professional and proper labeling

Policy: Procedures

- Step-by-step procedures: 5 Rights
- Which forms are necessary prior to administering medication
- How health care professional's orders will be handled:
  - telephone orders
  - child-specific orders
  - "as needed" orders
- The first dose of medication should be given by the parent/guardian at home
- Procedures for errors or incidents

Confidentiality

- Confidential information:
  - Information that someone may not want to share
  - Information that someone will give permission to share only on a "need to know" basis
- Establish and follow a written policy on confidentiality of the records of children
- Permission to share confidential information should be written, not just oral
- Policy may be further defined by state or local statute or regulation

Federal Law States…

- All medical records MUST be kept confidential:
  - Secure transfer of medical records
  - Permission required for electronic transfer of medical records
  - Confidential treatment of medical records
- Health Insurance Portability and Accountability Act (HIPAA) covers confidentiality in health care settings
- Family Educational Rights and Privacy Act (FERPA) applies to school settings but not specifically to child care settings

Receiving Medication: Prescription

Original medication packaging should have:

- Pharmacy name and number
- Prescriber's name and number
- Prescription number
- Date prescription was filled
- Child's first and last name
- Name of medication
- Strength of medication
- Refills
- Quantity (QTY)
- Manufacturer (MFG)
- Expiration date
- Instructions for administration, dose, etc
- Instructions for storage

Receiving Medication: Over-the-Counter

- Verify that the strength of the medication is appropriate for the child's age
- Original medication packaging should have:
  - Product name
  - Active ingredients
  - Purpose
  - Uses
  - Warnings
  - Directions
  - Expiration date
  - Inactive ingredients
  - Specific instructions for child, dose, etc
  - Other information
- *Make sure nothing blocks the label*

Process to Receive Medication

- Receive medication
- Match label with permission form and instructions
- Log medication with Receiving Medication form
- Ask parent/guardian questions:
  - When was the last time it was taken?
  - How do you give your child medication?
  - What kinds of side effects may be caused by the medication?
  - What successful techniques do parents use?
- Store medication

Receiving Medication Form

- Child's name
- Name of medication
- Date medication received
- Safety Check
- Controlled substances need special tracking

If the necessary information is not present or doesn't match, DO NOT accept or give the medication until the issue is resolved

Safe Storage and Handling

- Child resistant caps
- Store in out-of-reach places
- Observe for signs of tampering
  - Packaging that shows cuts, tears, slices, or other imperfections
  - Anything that looks suspicious
- Check for special storage instructions
- Be aware of product look-alikes

Tips for Parent/Guardians

- Ask pharmacist to divide medication into 2 bottles, each with its own label
  - 1 to be kept at home and 1 to be kept at the child care facility
  - Pharmacists may “split” the prescription upon request
- Field Trips
  - Ask if medication can be taken at an alternate time

Medication Storage Video

Medication Storage

Designated area
- Secured, locked cabinet
- Cool, dark place
- Limited access

Refrigeration
- If needed
- 36°F to 46°F
- Separation from food
- Spill-proof container

Staff Medication

- Staff medication should be stored safely and should not be accessible to children
- Staff medication should not be kept in unsecure purses or bags

Exceptions to Locked Storage

- Non-prescription diaper creams
- Non-prescription sunscreen
- Emergency medications (EpiPen®, asthma rescue medications, Glucagon®, Diastat®)
  - Emergency medications should stay close to children and can be stored in a pouch that stays with a supervising adult
- All of the medication listed above must be stored out of the reach of children

Create a Safe Medication Administration Area

A safe medication area is:

- Situated where the designated medication administration person is able to concentrate on administering medication
- Stocked with medication and supplies within easy reach
- Clean, well lit, and free of clutter
- Confidential and quiet

Disposing of Medication

- If medication or order is out-of-date or medication is left over, return to parent for disposal and record that on the permission or intake form
  - This is the preferred method
- If medication cannot be returned to parents, dispose of the medication in a secure trash container that children cannot access
- Controlled medication needs special disposal procedures
- Contaminated medication should be disposed of and replaced promptly

Scenario 1: Nick

- Nick is 15-months-old and has an ear infection. Nick needs a noon time dose of amoxicillin suspension for this week and part of next week. The medication requires refrigeration and it must be shaken before being given. Nick has already received several doses of amoxicillin at home.

Scenario 2: Maria

- Maria is 3-years-old and has eczema. She needs hydrocortisone cream applied to her arms at noon time. This is an OTC medication with a brand name of Aveeno®. Aveeno® also makes other non-medicated skin moisturizers as well, but the medication that is being requested is an OTC hydrocortisone cream. Maria has had this medication before.

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

_____ ____/____/____
Name of Facility/School Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

_____
Prescribing Health Professional's Name

_____
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Address

_____
Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

Safety Check

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

_____

Caregiver/Teacher Name (Print)

_____

Caregiver/Teacher Signature

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*
   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Emergency Contact Form

To Be Completed By Parent(s)		
Date form completed	Revised	Initials

Child's Name:	Birth Date:	Nickname:
Home Address:		
Parent/Guardian Name:		
Home Phone Number:	Work/Cell Phone Number:	
Emergency Contact Names & Relationship:		
Home Phone Number:	Work/Cell Phone Number:	
Primary Language:	Phone Number(s):	
Physicians:		
Primary Care Physician:	Emergency Phone:	
	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Does the Child Have Health Insurance? ☐ Yes ☐ No	If Yes, Name of the Child's Insurance Carrier:	
I give my consent for my child's Health Care Provider and Child Care Provider to discuss information on this form.		
Signature:		Date:

Sample Prescription Label

AJ's Pharmacy
444 Medicine Way
Blue Sky, NC 27599

Keep your family healthy for less

Dr. E. Donoghue
(732) 775-5500

PH (800)333-6868

NO 0123456-78907

DATE 09/20/2009

Nick Sample
123 Main Street
Anywhere, USA

Take one teaspoon by mouth three times daily for 10 days

Shake before using.

Amoxicillin Suspension 250 mg/5 cc

MFG BIGCOMPANY

NO REFILLS - DR. AUTHORIZATION REQUIRED

USE BEFORE 06/2020

Sample OTC Label

Effective Relief of Itching from Inflammation and Rashes due to:
Eczema *Psoriasis *Seborrheic Dermatitis
Poison Ivy *Oak *Sumac *Insect Bites
Detergents *Soaps *Cosmetics *Jewelry

Aveeno

1% HYDROCORTISONE ANTI-ITCH CREAM

Drug Facts

Active ingredient — **Purpose**
Hydrocortisone 1% ……..Anti-itch

Uses
*provides temporary relief of the itching associated with minor skin irritations, inflammation, and rashes from:
*eczema *psoriasis *insect bites *seborrheic dermatitis *soaps *poison ivy *poison oak *poison sumac *jewelry *cosmetics *detergents
*other uses of this product should be only under the advice and supervision of a doctor

Warnings
For external use only

Do not use *in the eyes *for the treatment of diaper rash

When using this product do not begin the use of any other hydrocortisone product

Stop use and ask a doctor if
*symptoms last for more than 7 days *the condition gets worse *symptoms clear up and come back in a few days

Drug Facts (continued)

Warnings (continued)
Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions
*adults and children 2 years and older: apply to affected area not more than 3-4 times daily
*children under 2 years of age: do not use, ask a doctor

Inactive ingredients
Aloe barbadensis leaf juice, Avena sativa (oat) kernel flour, beeswax, cetyl alcohol, citric acid, glyceryl stearate, isopropyl myristate, methylparaben, PEG-40 stearate, polysorbate 60, propylene glycol, propylparaben, sodium citrate, sorbic acid, sorbitan stearate, stearyl alcohol, tocopheryl acetate, water

Other information
Store at room temperature. Protect from freezing and excessive heat.

Questions? 1-877-298-2525

Exp 10/200X

Sample Policy Activity

NCCCHCA Medication Administration Policy

Belief Statement

Best Practice[1]:

- Families should check with the child's physician to see if a dose schedule can be arranged that does not involve the hours the child is in the child care facility.

Intent Statement

This policy is intended to ensure safe administration of medication to children with chronic conditions, mild illnesses or special health needs for whom a plan has been made and the plan has been approved by the Director: Mr. Oscar Meier Weiner.

Background

Almost all children require medication at some point in time. Administration of medication poses a liability and an extra burden for staff, and having medication in the facility is a safety hazard.

Administration of medication requires clear, accurate instruction and knowledge of why a child needs the medicine. Child care providers need to be aware of what the child is receiving, when it is to be given, how to read the label directions in relation to the measured doses, frequency, expiration dates, and be aware of any side effects. This policy applies to all medication administration for any child within the facility.

Procedure/Practice

I. Written Authorization:

1. Medication will be administered only if the parent or legal guardian has provided written, signed and dated consent to include:
   - child's first and last name
   - name of medication
   - time the medication should be given and how often
   - criteria for the administration of the medication
   - how much medication to give
   - manner in which the medication shall be administered (oral, topical, injection, etc.)
   - medical conditions or possible allergic reactions
   - length of time the authorization is valid, if less than six months
2. The length of time the consent is valid:
   a) Up to six months:
      1. A prescription medication shall be valid for the length of time the medication is prescribed to be taken up to six months.
      2. Prescription or over-the-counter medication, when needed, for chronic medical conditions and for allergic reactions.

   b) Up to 30 days:
      1. Other over-the-counter medications except as allowed in Items (c),(d),(e), or (f) below:

   c) Up to 12 months:

1. To apply over-the-counter, topical ointments, gels, lotions, creams, or powders such as sunscreen, diapering creams, baby lotion, baby powder, insect repellant or teething gel to a child, when needed.

d) Valid for as long as the child is enrolled:
1. Standing authorization to administer an over-the-counter medication as directed by the North Carolina State Health Director or designee, when there is a public health emergency as identified by the North Carolina State Health Director or designee. This permission will include a statement that the authorization is valid until withdrawn by the parent/guardian in writing.

e) At any time:
1. A parent/guardian may withdraw his or her written authorization for the administration of medications at any time in writing.

f) Standing authorization: (option to omit for best practice)
1. A written statement signed by the parent/guardian may give standing authorization for a one time weight appropriate dose of acetaminophen if the child has a fever and the parent/guardian can not be reached.

3. If any question arises concerning whether medication provided by the parent/guardian should be given, a physician's note must accompany the medication.
4. Exception to Authorization:
A caregiver may administer medication to a child without parental authorization in the event of an emergency medical condition when the child's parent/guardian is unavailable. The medication must be administered with the authorization and in accordance with instructions from a bona fide medical care provider.[3]

II. Prescription Medication: [2]

Prescription medications such as antibiotics, seizure medications or others:
1. Must be administered only to the child for whom they were prescribed.
2. Must be in its original child resistant container labeled by a pharmacist to include:
   - child's first and last name
   - name of medication
   - date prescription was filled
   - name of health professional who wrote the prescription
   - medication expiration date, storage information
   - instructions on administration: dosage amount, frequency, and specific indications for "as needed". (An accompanying sheet with this written information is acceptable. It must bear the child's name and be signed and dated by the physician.) See definitions section for more information.
3. Pharmaceutical samples must be stored in the manufacturer's original packaging, must be labeled with the child's name, and shall be accompanied by written instructions as for all prescriptions.

III. Over-the-Counter Medications: [3]

Over-the-Counter (OTC) medications such as cough syrup, decongestant, acetaminophen, ibuprofen, topical antibiotic cream for abrasions, or medication for intestinal disorders:
1. Must be in the original container labeled by the parent or legal guardian with the child's first and last names.
2. Must be accompanied by written instructions signed and dated by the parent or guardian specifying:
   - child's first and last name
   - name of the medication
   - conditions for use
   - dose of the medication
   - how often the medication may be given
   - manner in which the ointments, repellents, lotions, creams, and powders shall be applied
   - any precautions to follow
   - length of time the authorization is valid

3. Administered as authorized with specific, legible written instructions by the parent or legal guardian not to exceed amounts and frequency of dosage specified by the manufacturer.
4. If manufacturer's instructions include consultation with a physician for dose or administration instructions, written dosage instructions from a licensed physician or authorized health professional is required.

IV. Medication will not be given if it is:[2]

1. not in the original container
2. beyond the date of expiration on the container
3. without written authorization
4. beyond expiration of the parental or guardian consent
5. without the written instructions provided by the physician or other health professional legally authorized to prescribe medication
6. in any manner not authorized by the child's parent/guardian, physician or other health professional
7. for non-medical reasons, such as to induce sleep

V. Receipt, Storage and Disposal: [1,2,5]

1. All medications brought in to the center will be given to the Director for review and approval.
2. Medications will be stored in a sturdy, child-resistant, locked container that is inaccessible to children and prevents spillage.
3. Medications will be stored at the temperature recommended for that type of medication. It shall not be stored above food. A lock box can be kept in a designated refrigerator not accessible to children to hold medications.
4. Emergency medication may be left unlocked so long as they are stored out of the reach of children at least 5 feet above the floor.
5. Non-prescription diaper creams shall be stored out of reach of children at least 5 feet above the floor, but are not required to be in locked storage.
6. Any medication remaining after the course of treatment is completed or authorization is withdrawn will be returned to the parent/guardian within 72 hours or it will be discarded. Contact your Child Care Health Consultant or Health Department for instructions on how to properly discard. If discarded, another staff will witness and sign to the fact it was discarded and how it was discarded.

VI. Training: [1]

1. Only staff persons who have documentation of medication administration training by a licensed health care professional will administer medication.
2. A staff member trained in medication administration will be on site at all times when children are present.

VII. Documentation: [2]

1. A medication log will be maintained in the child's file by the facility staff to record any time prescription or over-the-counter medication is administered by child care facility personnel.
2. The child's name, date, time, amount and type of medication given, and the name and signature of the person administering the medication shall be recorded for each administration.
3. The log may be part of the medication permission slip or on a separate form developed by the provider which includes the required information.
4. Only one medication shall be listed on each form.
5. Spills, reactions, and refusal to take medication will be noted on this log.
6. No documentation shall be required when over-the-counter, topical ointments, gels, lotions, creams, and powders – such as sunscreen, diapering creams, baby lotion, baby powder, topical teething products, or insect repellents – are applied to children.

VII. Medication Error: [2]

1. In the event of a medication error, the appropriate first aid or emergency action will be taken.

2. Director, parent/guardian, and as needed, the nurse or physician will be notified.
3. A medication error and an incident report will be prepared.

Applicable:

This policy applies to all staff, families, volunteers, and visitors who use the child care services at Laughing Lots Child Care.

Communication:

1. Staff: will review policy, and sign they have reviewed policy during orientation, yearly and if revisions are made.
2. Parent/Guardian: will be notified by letter and handbook and will sign for receipt.

References:

[1]Caring for Our Children – Second Edition
[2]NC Child Care Law GS 110-91 and NC Child Care Rule: 10A NCAC 09 .0803
[3]NC GS 110-102.1A
[4]Model Child Care Health Policies 3rd edition
[5]NC Environmental rule: 15A NCAC 18A .2820(d)

Review/Approval:
This policy will be reviewed and approved by:

Owner/ director	date 8/2/06
DCD Consultant	date 8/3/06
Child Care Health Consultant	date 08/02/06
Other as applicable	date 8/2/06

Effective Date: August 7, 2006

Annual Review Date: 08 07 2007

Definition:

II.2 As needed medications: A physician may state that a certain medication may be given for a recurring problem, emergency situation, or chronic condition. The instructions should include the child's name; the name of the medication; the dose of the medication; how often the medication may be given; the conditions for use; and any precautions to follow. For example:

- A child may have sunscreen applied as needed to prevent sunburn;
- A child who wheezes with vigorous exercise may take one dose of asthma medicine before vigorous active (large muscle) play;
- A child with a known serious allergic reaction to a specific substance who develops symptoms after exposure to that substance may receive epinephrine from a staff member who has received training in how to use an auto-injection device prescribed for that child (e.g., Epipen®).

NC Policy Review: What is missing?

Instructions: Review a NC MA Policy. Put a check to see if the policy elements listed on this page are present in the policy.

Title	
Belief Statement	
Intent Statement	
Background	
Procedures	
Authorization	
Prescription	
OTC	
Receipt	
Storage	
Disposal	
Training	
Documentation	
Error	
Applicable	
Communication	
References	
Reviewed by	
Effective Date	
Review Date	

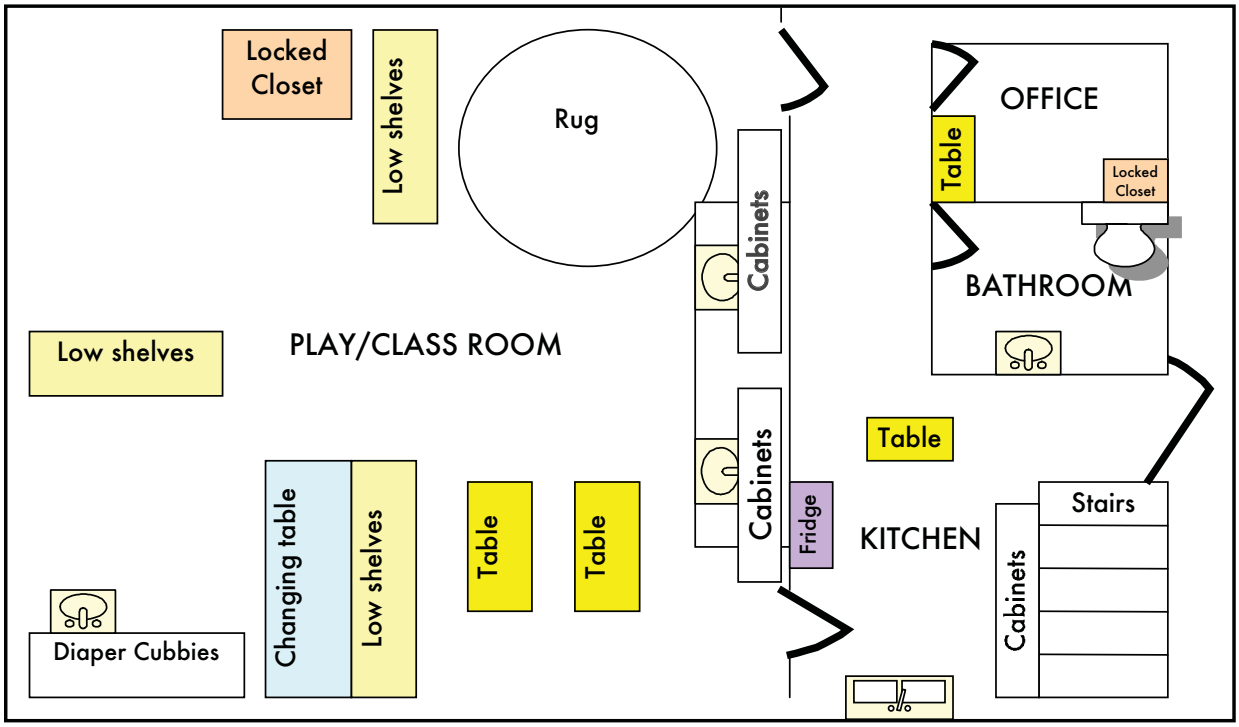
Medication Administration Policy Checklist

- Title: A couple of words that describe the content of the policy plus a numerical code, if applicable.
- Belief Statement: A brief statement about why the center believes the policy is necessary. A facility may include policy options, best practice or NC law. (Example: XYZ Child Care believes all children have the right to safe medication administration practices in child care.)
- Intent Statement: An explanation of the purpose of the policy. (Example: This policy is intended to prevent errors in medication administration and provide child care providers with a plan in case of an emergency.)
- Background: A description of why the policy was developed. Not every policy will have a background statement.
- Procedure/Practice: Action steps necessary to accomplish what the policy recommends.
  - Written Authorization
  - Prescription Medication
  - Receipt
  - Disposal
  - Training/Who will give medication
  - Written/Telephone Instructions
  - Over-the-Counter Medication
  - Storage
  - Documentation
  - Medication Error
- Applicable: To whom does the policy apply? (Children, staff, families, etc)
- Communication: How are families/staff informed about the policy? (Parent handbook, newsletter, etc)
- References: What information was used to develop the policy or procedure? (Books, journal articles, Internet sources, etc)
- Review: Who reviews policies at the center? (Director, CCHC, legal advisor, board, policy council, etc.) Each of these people need a professional signature and date.
- Effective Date: When will the policy be put into effect?
- Review Date: How often will the center review the policy? (Every 6 months, every year, etc)

FLOOR PLAN ACTIVITY
Where to store mediation!

Identify where to store the following items:

- Prescription medication
- Over-the-counter medication
- Emergency medication
- Preventive substances (sunscreen, etc)



A locked box is available to you.
The cabinets are 6 feet.
The low shelves are 3 feet.

Group Activity: Receiving Medication, Scenario 1

Nick is 15-months-old and has an ear infection. Nick needs a noon time dose of amoxicillin suspension for this week and part of next week. The medication requires refrigeration and it must be shaken before being given. Nick has already received several doses of amoxicillin at home.

Group Activity: Receiving Medication, Scenario 1

AJ's Pharmacy
444 Medicine Way
Blue Sky, NC 27599

Keep your family healthy for less

Dr. E. Donoghue
(732) 775-5500

PH (800)333-6868

NO 0123456-78907

DATE 09/20/2009

Nick Sample
123 Main Street
Anywhere, USA

Take one teaspoon by mouth three times daily for 10 days

Shake before using.

Amoxicillin Suspension 250 mg/5 cc

MFG BIGCOMPANY

NO REFILLS - DR. AUTHORIZATION REQUIRED

USE BEFORE 06/2020

Group Activity: Receiving Medication, Scenario 1

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

ABC Child Care Center
Name of Facility/School

X / X / 20XX
Today's Date

Nick Sample
Name of Child (First and Last)

Y / Y / 0Y
Date of Birth

Name of Medicine Amoxicillin Suspension 250mg/5cc

Reason medicine is needed during school hours Ear Infection

Dose One teaspoon Route By mouth

Time to give medicine Noon

Additional instructions

Date to start medicine 0 / 0 / 20xx Monday Stop date X / X / 20xx

Known side effects of medicine Diarrhea

Plan of management of side effects Rice cereal and yogurt to eat

Child allergies None

PRESCRIBER'S INFORMATION

Elaine Donoghue, MD
Prescribing Health Professional's Name

(732) 775-5500
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Nicole Sample
Parent or Guardian Name (Print)

Nicole Sample
Parent or Guardian Signature

123 Main Street, Anywhere USA
Address

123-4567	234-5678	987-6543
Home Phone Number	Work Phone Number	Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Group Activity: Receiving Medication, Scenario 1

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)	(First)	Gender	Date of Birth
Sample	Nick	☒ Male ☐ Female	Y / Y / 2004

Does Child Have Health Insurance?	If Yes, Name of Child's Health Insurance Carrier
☒ Yes ☐ No	BC/BS

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Nicole Sample	123-4567	234-5678
Michael Sample	123-4567	987-6543

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC.
Nicole Sample	☒ Yes ☐ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: 2/2/2002 — Results of physical examination normal? ☒ Yes ☐ No

Abnormalities Noted: Ø

Weight *(must be taken within 30 days for WIC)*	25 lbs
Height *(must be taken within 30 days for WIC)*	30 inches
Head Circumference *(if <2 Years)*	46 cm
Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS — ☒ Immunization Record Attached ☐ Date Next Immunization Due: At two years of age

MEDICAL CONDITIONS

		Comments
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☒ None ☐ Special Care Plan Attached	
Medications/Treatments • List medications/treatments:	☒ None ☐ Special Care Plan Attached	Occasional ear infections
Limitations to Physical Activity • List limitations/special considerations:	☒ None ☐ Special Care Plan Attached	
Special Equipment Needs • List items necessary for daily activities	☒ None ☐ Special Care Plan Attached	
Allergies/Sensitivities • List allergies:	☒ None ☐ Special Care Plan Attached	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☒ None ☐ Special Care Plan Attached	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☒ None ☐ Special Care Plan Attached	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☒ None ☐ Special Care Plan Attached	

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct	2/2/2002	11/33	Hearing	Birth	Passed
Lead: ☒ Capillary ☐ Venous	2/2/2002	3	Vision		
TB (mm of Induration)			Dental		
Other:			Developmental	2/2/2002	Normal
Other:			Scoliosis		

☒ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp
Elaine Donoghue, MD	
Signature/Date: Elaine Donoghue XX/XX/XX	

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Group Activity: Receiving Medication, Scenario 1

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Nick Sample

Name of medicine Amoxicillin Suspension 250/5 cc

Date medicine was received X / X / 20XX

Safety Check

- ☐ 1. Child-resistant container.
- ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- ☐ 3. Name of child on container is correct (first and last names).
- ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
- ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- ☐ 6. Copy of Child Health Record is on file.
- ☐ 7. Instructions are clear for dose, route, and time to give medicine.
- ☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- ☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

Group Activity: Receiving Medication, Scenario 1

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

ABC Child Care Center — Name of Facility/School
X / X / 20xx — Today's Date

Nick Sample — Name of Child (First and Last)
Y / Y / 200y — Date of Birth

Name of Medicine Amoxicillin Suspension 250 mg/5cc

Reason medicine is needed during school hours Ear infection

Dose _____ Route By mouth

Time to give medicine noon

Additional instructions _____

Date to start medicine 0 / 0 / 20xx monday Stop date X / X / 20xx

Known side effects of medicine Diarrhea

Plan of management of side effects Rice cereal and yogurt to eat

Child allergies None

PRESCRIBER'S INFORMATION

Elaine Donoghue, MD
Prescribing Health Professional's Name

(732) 775-5500
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Nicole Sample
Parent or Guardian Name (Print)

Nicole Sample
Parent or Guardian Signature

123 main St., Anywhere USA
Address

123-4567	234-5678	987-6543
Home Phone Number	Work Phone Number	Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Group Activity: Receiving Medication, Scenario 2

Maria is 3-years-old and has eczema. She needs hydrocortisone cream applied to her arms at noon time. This is an OTC medication with a brand name of Aveeno®. Aveeno also makes other non-medicated skin moisturizers as well, but the medication that is being requested is an OTC hydrocortisone cream. Maria has had this medication before.

Group Activity: Receiving Medication, Scenario 2

Effective Relief of Itching from Inflammation and Rashes due to:
Eczema *Psoriasis *Seborrheic Dermatitis
Poison Ivy *Oak *Sumac *Insect Bites
Detergents *Soaps *Cosmetics *Jewelry

Aveeno

1% HYDROCORTISONE ANTI-ITCH CREAM

Drug Facts

Active ingredient **Purpose**
Hydrocortisone 1% ……..Anti-itch

Uses
*provides temporary relief of the itching associated with minor skin irritations, inflammation, and rashes from:
*eczema *psoriasis *insect bites *seborrheic dermatitis *soaps *poison ivy *poison oak *poison sumac *jewelry *cosmetics *detergents
*other uses of this product should be only under the advice and supervision of a doctor

Warnings
For external use only

Do not use *in the eyes *for the treatment of diaper rash

When using this product do not begin the use of any other hydrocortisone product

Stop use and ask a doctor if
*symptoms last for more than 7 days *the condition gets worse *symptoms clear up and come back in a few days

Drug Facts (continued)

Warnings (continued)
Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions
*adults and children 2 years and older: apply to affected area not more than 3-4 times daily
*children under 2 years of age: do not use, ask a doctor

Inactive ingredients
Aloe barbadensis leaf juice, Avena sativa (oat) kernel flour, beeswax, cetyl alcohol, citric acid, glyceryl stearate, isopropyl myristate, methylparaben, PEG-40 stearate, polysorbate 60, propylene glycol, propylparaben, sodium citrate, sorbic acid, sorbitan stearate, stearyl alcohol, tocopheryl acetate, water

Other information
Store at room temperature. Protect from freezing and excessive heat.

Questions? 1-877-298-2525

Exp 10/200X

Group Activity: Receiving Medication, Scenario 2

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

ABC Child Care Center — Name of Facility/School
X/X/200X — Today's Date

Maria Test — Name of Child (First and Last)
Y/Y/200Y — Date of Birth

Name of Medicine: Hydrocortisone 1% - Aveeno

Reason medicine is needed during school hours: Skin rash

Dose: Apply to arms — Route: On Skin

Time to give medicine: 1:00 pm

Additional instructions: Apply thin layer

Date to start medicine: X/X/200X — Stop date: Z/Z/2002

Known side effects of medicine: Skin redness

Plan of management of side effects: Stop putting on cream

Child allergies: None

PRESCRIBER'S INFORMATION

Elaine Donoghue, MD
Prescribing Health Professional's Name

(732) 775-5500
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Maria Test
Parent or Guardian Name (Print)

Maria Test
Parent or Guardian Signature

123 City Road, Urbantown USA
Address

987-6543 — Home Phone Number
876-5432 — Work Phone Number
123-4567 — Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Group Activity: Receiving Medication, Scenario 2

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)	(First)	Gender	Date of Birth
Test	Maria	☐ Male ☒ Female	Y / Y / 200Y

Does Child Have Health Insurance?	If Yes, Name of Child's Health Insurance Carrier
☒ Yes ☐ No	BC/BS

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Maria Test	987-6543	876-5432
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Hector Test	987-6543	123-4567

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC.
Maria Test	☒ Yes ☐ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☒ Yes ☐ No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	35 lbs
	Height *(must be taken within 30 days for WIC)*	36 inches
	Head Circumference *(if <2 Years)*	—
	Blood Pressure *(if ≥3 Years)*	90/50

IMMUNIZATIONS	
	☒ Immunization Record Attached ☐ Date Next Immunization Due: At 4 years of age

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments Eczema
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments Hydrocortisone 1% to affected areas Apply thin layer
Limitations to Physical Activity • List limitations/special considerations:	☒ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☒ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments Seasonal Allergies
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☒ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☒ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☒ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct	X/X/200X	11.5/34	Hearing	Birth	Pass
Lead: ☐ Capillary ☐ Venous	X/X/200X	5	Vision		
TB (mm of Induration)	X/X/200X	Neg	Dental		
Other:			Developmental	X/X/200X	Normal
Other:			Scoliosis		

☒ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp
Elaine Donoghue, MD	
Signature/Date Elaine Donoghue,	

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Group Activity: Receiving Medication, Scenario 2

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Maria Test

Name of medicine Hydrocortisone 1%

Date medicine was received X / X / 200x

Safety Check

- ☐ 1. Child-resistant container.
- ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- ☐ 3. Name of child on container is correct (first and last names).
- ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
- ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- ☐ 6. Copy of Child Health Record is on file.
- ☐ 7. Instructions are clear for dose, route, and time to give medicine.
- ☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- ☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

Group Activity: Receiving Medication, Scenario 2

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

ABC Child Care Center — Name of Facility/School
X / X / 20xx — Today's Date

Maria Test — Name of Child (First and Last)
Y / Y / 200Y — Date of Birth

Name of Medicine: Hydrocortisone 1% - Aveeno

Reason medicine is needed during school hours: Skin rash

Dose: Apply to arms — Route: On Skin

Time to give medicine:

Additional instructions: Apply thin layer

Date to start medicine: X / X / 200x — Stop date: 2 / 2 / 2002

Known side effects of medicine: Skin redness

Plan of management of side effects: Stop putting on cream

Child allergies: None

PRESCRIBER'S INFORMATION

Elaine Donoghue, MD
Prescribing Health Professional's Name

(732) 775-5500
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Maria Test
Parent or Guardian Name (Print)

Maria Test
Parent or Guardian Signature

123 City Road, Urbantown USA
Address

987-6543 — Home Phone Number
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MODULE 3

How to Administer Medication

- Introduction: top common errors
- 5 Rights
- Identifying “as needed” conditions
- Universal/standard precautions
- Preparing to administer medication
- Medication administration procedure
- Communicating with the child

MODULE 3

How to Administer Medication

- Introduction: most common errors
- 5 Rights
- Identifying “as needed” conditions
- Universal/standard precautions
- Preparing to administer medication
- Medication administration procedure
- Communicating with the child

Introduction: Common Errors in Medication Administration

7,000 children per year require emergency department visits for medication problems

- Common errors
  - Took medication twice
  - Wrong medication
  - Incorrect dose
  - Missed dose
- Common causes
  - Not understanding medication label
  - Not understanding how to give medication
  - Poor communication between parents/guardians and health care professional

Most Common Medication Errors

- Errors are most commonly made with analgesics, which is the class of medication which includes Tylenol® (acetaminophen) and Motrin® (ibuprofen)
- Reasons for errors include:
  - These medications are given frequently
  - There are many different concentrations (infant drops, children’s liquids, etc)
  - They are often mixed with other medications in cough and cold preparations
  - Dosing charts are unique to the type and form of the medication

The “5 Rights”

- Right child
- Right medication
- Right dose
- Right time
- Right route

Right Child

- Check the name on the medication label and the child’s name
- If any question arises, check a second identifier such as date of birth

Right Medication

- Read the label to make sure you have the correct medication
- Check to see:
  - Medication is in the original labeled container
  - Expiration date is not exceeded
- Especially important for children who are taking more than 1 medication

Right Dose

- Check dose on label and authorization form
- Use proper measuring device
- Check measuring device carefully

Right Time

- Check the permission form to match the time with the label
- Check that medication is being given within 30 minutes before or after prescribed time
- Look at the clock and note the time
- The right time includes both time and date
- In an emergency, “now” is the right time to give medication

Right Route

- Check the label and Authorization to Give Medicine form
- How is the medication to be given?

"As Needed" Conditions

- Some medication, such as emergency medication, only need to be given "as needed"
- Health care professionals and other prescribers should not write "as needed" or "prn" without more specific instructions
  - Example of acceptable, specific instructions: albuterol – 2 puffs as needed for wheezing, increased cough, or breathing difficulty
- OTC medication for pain and fever should be kept to a minimum and should be as specific as possible
- The order should state the maximum number of times the dose can be repeated before seeking further medical care

Standard Precautions in Child Care Settings

Standard Precautions

- The term for the infection control measures that all heath and child care providers should follow in order to protect themselves from infectious diseases and to prevent the spread of infectious diseases to those in their care
- Sometimes called universal precautions

Standard Precautions in Child Care Settings

What Do They Consist Of?

- Handwashing
  - Handwashing with soap and water should be done before medication administration
  - An individual towel should be available for each handwashing
  - Hand sanitizers (alcohol based rubs) should be limited to times when soap and water are not available
  - Hand sanitizers should be kept out of reach of children and their use should be supervised
- Disposable gloves
- Proper disposal of materials
- Environmental sanitation

Group Activity: Prepare to Administer Medication to Nick

- List the steps to prepare to give medication to Nick

Group Activity: Prepare to Administer Medication to Nick, continued

Steps

- Wash hands
- Prepare work area
- Take out the medication
- Check the label and the items on the forms to see that they match
- Get proper measuring device
- Check the time

Medication Administration Procedure: Prepare the Medication

- Find appropriate measuring device
- Measure the amount on the label
- Change the form of the medication ONLY if label states for you to do so:
  - Crushed or powdered medication
  - Sprinkles
  - Mix with food

Medication and Food

- It is usually best not to mix medication with food, but it may be necessary
- Ask the prescriber or pharmacist before mixing medication with food or liquid
- If medication is mixed with food or liquid, ALL of it must be taken
- Give the child something to drink immediately afterward to help with the taste

Medication Administration Procedure: Prepare the Child

- Communicate with the child
- Explain the procedure to the child
  - *Never call medication "candy"*
- Wash the child's hands, if appropriate
- Position the child

Prepare the Child: Infants

- Support the infant's head
- Hold the baby semi-upright
  - An infant seat may be used
- Keep the infant's arms and hands away from her face
- Gently press the chin to open the mouth
- Rock the baby before and after
- Syringe or dropper:
  - Position on one side of the mouth along the gum
  - Squirt slowly to allow time to swallow
- Special dosing nipples work best when the baby is hungry
- Give oral medication before feeding unless instructed otherwise

Prepare the Child: Toddlers

- Ask parents what techniques they use
- Give toddlers some control, like sitting or standing, but do not give veto power over taking the medication
- Be honest about bad taste and allow the child to drink afterwards
- Use age-appropriate language to explain what you are doing
- Maintain an attitude that you expect cooperation
- Thank the child for their cooperation and praise them

Prepare the Child: Older Children

- Explain why we take medication and why they help us to get better
- Use the opportunity to teach about time, body parts, health, and illness
- Involving the child in the process helps to prepare him to take his own medication as he gets older
- Books that talk about medication are helpful to read with the child

Medication Administration Procedure

- Check 5 rights: child, medication, dose, time, and route
  - Note any special instructions
- Take the medication from the container
  - Prepare the medication
- Check the label again
- Give the medication
  - *Never give more or less, accuracy is very important*

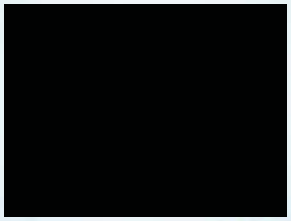
Medication Administration Procedure: Finishing Up

- Praise the child
- Check the label again
- Return the medication to storage immediately
  - Never leave medication unattended
- Record the medication, date, time, dose, route, and your signature on the Medication Log
- Clean the measuring device
- Wash your hands
- Observe the child for side effects

After Giving Medication

- Allow the child the opportunity to express his or her feelings
- Acknowledge that some medication is difficult to take
- Encourage the child that next time will be easier
- Offer to spend time with the child

Oral Medication Video: How to Give Oral Medication



Measuring Oral Medication

- Oral Measuring Devices
  - Dropper
  - Syringes: ½ tsp or less is most accurately measured with syringe or similar device
  - Dosing spoon
  - Medication cup
- *No kitchen teaspoons!*

Topical Medication Video: How to Give Topical Medication

Topical Medication Video: How to Give Eye Drops

Topical Medication Video: How to Give Ear Drops

Topical Medication

- Skin creams, ointments, patches
- Eye drops, ointments
- Ear drops

Inhaled Medication

- Nasal sprays and drops
- Metered dose inhalers and nebulizers

5 Rights of Medication Administration — Rationale and Considerations

Right Thing to Do	Rationale and Issues to Consider
1. Right Child	• Determine who is authorized to give medication and that this person knows the children who are to receive the medication by sight and name so that mix-ups are less likely to occur. • Check the name on the medication label to be sure that the name on the label is the name of the child to receive the medication. Giving the medication to a child who is not supposed to receive it could cause a bad reaction for the child who receives the medication and a missed dose for the child who should receive the medication. • If the child can talk, ask the child to say his or her name. Confirm the identity of the child with the child's picture and with another person if possible. Avoiding a mix-up requires care and diligence.
2. Right Medication	• A medication intended for someone else or for some other purpose may be the wrong strength and might cause side effects. • Parents might deliberately give medication intended for another family member to the child care provider to treat symptoms that the parent thinks the child will benefit from the medication. Parents might inadvertently bring another family member's medication to the child care provider instead of the right medication. • Compare the instructions on the label to the instructions the parent wrote with the written permission to give the medication to be sure they are the same. • Read the label when receiving the medication from the parent and check it against the safety precautions list; read it again when taking the medication from the storage place in the child care facility; read it again when measuring out the medication. • Check that the instruction is correct each time and that the instruction is still current. Sometimes the child's health care professional changes a medication before the course ends and parents may forget to tell the child care provider about the change.

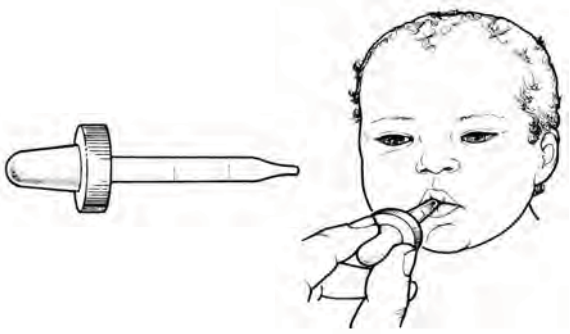
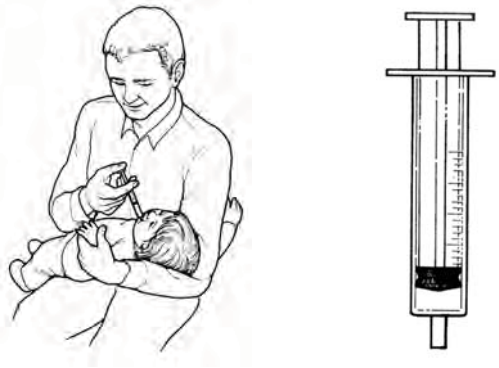
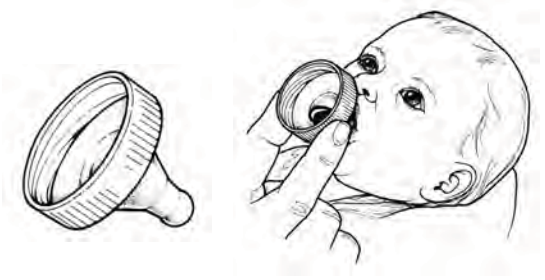
3. Right Dose	• This course gives some detail about oral medications, and mentions other types of medications. To be sure you know how to measure the right dose of any type of medication, you need specific training for the ones you give. • Parents should provide an accurate measuring device with the medication. Before the device is reused, it should be washed in a dishwasher or by hand using a dishwashing technique to remove any residue of old medication and for sanitation. If a dose-measuring device is supplied by the child care provider, traces of medication that remain in the device could cause an allergic reaction for another child who uses the device at another time. • Measuring oral medications requires use of measuring devices that accurately hold the right amount of medication. Common eating utensils (teaspoons and tablespoons) do not accurately measure medications. Cooking measures or medication measuring devices must be used. o Milliliter (ml) = cubic centimeter (cc) o 5 cc or ml = 1 filled cooking measure teaspoon o Read the level of medication in a cup or measuring device at eye level, preferably with the bottom of the device on a flat surface. Make the lower edge of the measured liquid (meniscus) reach the correctly labeled line on the measuring device. o Other devices to measure liquid medications include oral syringes, marked measuring medication cups, dosing spoons with an attached measuring tube to hold the liquid until the child takes the medication, dropper that comes with the medication intended to be used with that medication that is marked with a line to show where in the dropper to bring up the liquid, medication measuring nipple device for infants. • Tablets come as a chewable type or a type that must be swallowed. o Chewable tablets must be chewed completely. Those that are not chewable should not be chewed or crushed unless the child's health care professional gives that instruction. o Tablets that are scored may be cut in half with a pill cutter or a thin, sharp paring knife. The tablet should be split in 2 by the pharmacist or parent. o Tablets that are not scored may not be cut because the medication may not be evenly distributed in the tablet. • Capsules are generally to be swallowed. Those that may be opened and sprinkled into a small amount of food are specifically labeled as such. No others may be opened.

4. Right Time	• Spacing of doses determines the level of the medication that remains in the place where it is needed. Giving the medication at the wrong time can make the level too high or too low at one time or another, producing side effects or inadequate treatment. • Aim to give medication within a window of 30 minutes before, or 30 minutes after it is due. • Check with the parent daily to see when the last dose was given to be sure when the next dose is due. (Verify that there has been no change of plan at this time also.) Check the medication record to see that the note about when the dose is due is correct, and record the dose when it has been given. Parents and other staff must be clear about when the next dose after the 1 you are giving is due. • Check to see if the medication should be given before food or with food. Food slows absorption of medication and may interfere with complete absorption into the body. Medications that must be given without food should be given at least 1 hour before eating to be fully absorbed before food enters the stomach. • Doses that must be given multiple times each day should be as evenly spaced during the child's waking hours as possible. • Whenever possible, see if the child's health care professional can choose a schedule for giving the medication that minimizes the giving of medication while the child is in child care. The child can have medications that can be given as 2 doses a day at home in the morning and when the child gets home at the end of the day.

5. Right Route and Procedure	• Medications are designed for the specific opening and surface of the body where they are to be used. Using them in a different place may injure body tissues and may not work. • Locations where medications are designed to enter the body: o Mouth (oral liquids/drops, tablets, capsules) o Eye (ophthalmic drops and ointments) o Ear (otic drops) o Nose (nasal drops and sprays) o Airway (inhaled aerosols and powders) o Rectum (rectal — usually suppositories) o Skin (lotions, creams, ointments) o Through the skin (injected, usually with a needle and syringe) • Always wash your hands before and after giving any medication. If the child will touch the medication, have the child wash too. • Never mix medication in a baby bottle, in water, or juice unless the instructions to do so come from the child's health care professional. Even then, keep the volume small (1 teaspoon to 1 tablespoon) to be sure the child will get all of the dose of the medication. • Pour liquid medication from the side opposite the label so the label stays readable if medication drips down the side of the bottle. • Be careful not to pour too much; don't pour any liquid medication back into the bottle. • Hold infants in a cradle position to administer medication. Allow a toddler to sit up in a chair. • A syringe adapter device is available that fits on the medication bottle to make removing liquids from a bottle into an oral syringe easier. Using an oral syringe with an infant helps to prevent spilling of the medication. • If you use an oral syringe, hold the child so the child's mouth is facing up. Put the tip of the syringe in the space between the cheek and the back of the mouth where the upper and lower gums meet, letting off small amounts of the medication while the child swallows each little squirt. • If the child doesn't get all the medication (spits it out, spills it, or vomits some of it), do not give another does unless the child's health care professional says to do so.

Oral Medication: Liquid

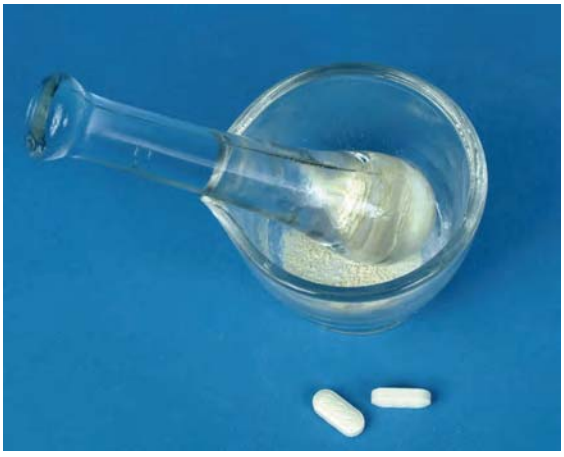
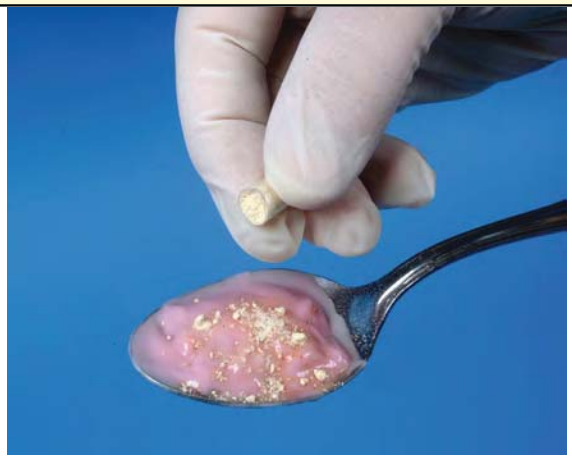
1. Wash hands and child's hands.
2. Position the child.
    a. Infants – Hold in the cradle position.
    b. Toddlers – Allow to sit up in a high chair.
3. Choose proper measuring device.

Dropper –	**Syringe –**
a. Withdraw the correct dosage amount of medicine. b. Place the dropper into the side of the mouth. c. Squeeze the dropper. d. Give a small amount at a time. 	a. Place the tip of the syringe into the liquid and pull back the plunger. b. Read the amount of liquid at the bottom of the semicircle at the top of the liquid. c. Avoid air bubbles by keeping the tip below the level of the liquid. d. Slowly squirt very small amounts toward the back and sides of the child's mouth. 
Nipple –	**Medicine Cup –**
a. Place an empty bottle nipple in the child's mouth. b. Measure the drug in nipple. c. Allow the child to suck the nipple. d. Give a small amount at a time. 	a. Pour medication from the side opposite the label so the label stays readable, in case medicine drips down the side of the bottle. b. Give a small amount at a time. c. If not all is taken from the cup pour a little water to rinse the drug from the sides of the cup. 

4. Stroke the side of the neck to stimulate swallowing.
5. Always follow with a bottle or drink. (This rinses the child's mouth to remove any of the sweetened drug from the gums and teeth.)
6. Wash hands and document medication administration.

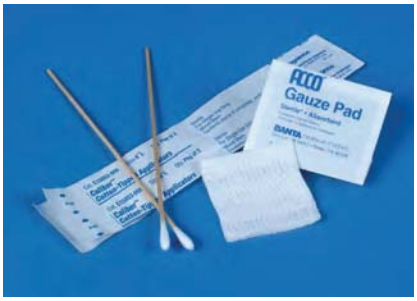
Oral Medication: Tablets/capsules

1. Wash hands and child's hands.
2. Pour tablets or capsules into a medicine cup, the lid of the bottle, or a small paper cup or paper towel.
3. For toddlers: Tell child to pick up the medicine themselves and put it in his or her mouth.
4. For infants: Cut, crush, sprinkle, or mix medicine (ONLY if directed to do so). Avoid cutting tablets. Ask parent/guardian to do this. Mix medicine with 1 teaspoon of liquid or soft food like applesauce or pudding, if approved by a health care professional.
5. If you have to put medicine directly into a child's mouth, you may want to put on disposable gloves so you do not transfer germs. Hand washing before and after is sufficient, however. Dispose of the gloves, if used, after each use.
6. Wash hands and document medication administration.

CUT	CRUSH
	
SPRINKLE	**MIX**
	

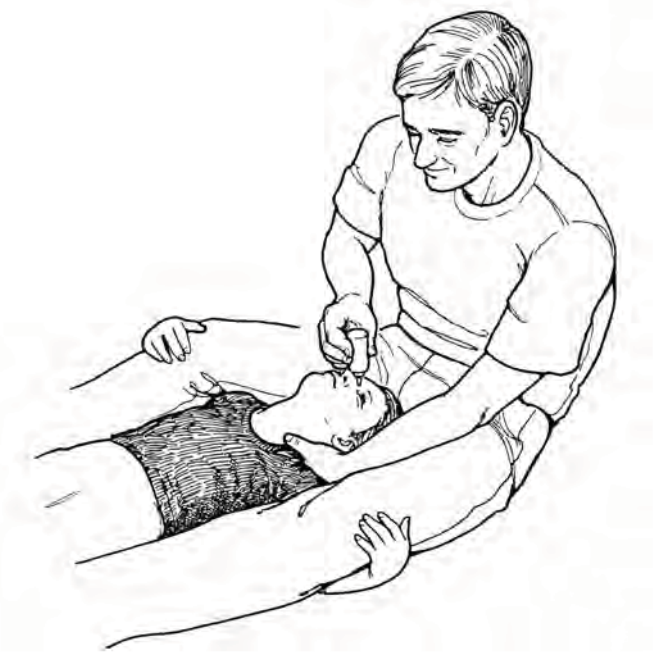
Topical Medication: Creams

1. Wash your hands.
2. Put on gloves.
3. Expose the area to be treated.
4. Clean the skin of debris including crusts or old medicine.
    a. Wet a washcloth or paper towel with warm water and place this over the area to be cleaned.
    b. Wait about 1 minute.
    c. Gently wipe the area.
    d. If you cannot remove the crusting rewet the cloth. They try to gently remove the crust or old medicine. Continue until all crusts or old medicine is removed.
    e. If using cloths, launder before using again.
5. Discard any soiled items and gloves.
6. Wash hands.
7. Open the container and place the lid or cap upside down to prevent contamination of the inside surface.
8. Use gloved hands or a tongue blade, gauze or cotton tipped applicator to apply the medicine.
9. Cover one end of the applicator with medicine from the tube or jar. (This step is not necessary with lotions.)
10. Apply the cream or ointment to affected area with applicator in smooth strokes.
11. Use a new applicator each time you remove medicine from the container to prevent contamination.
12. Use a small amount to cover the area and rub onto the skin.
13. If instructions state to cover the affected area, then place the medicine on the dressing, then cover the area with the dressing.
14. Wash hands and document medication adminstration.



Eye Medication

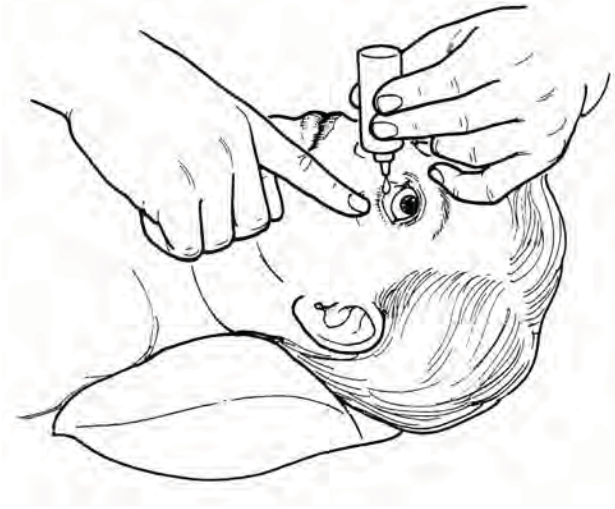
1. Wash your hands.
2. Clean child's eyes.
   a. Put on gloves.
   b. Use a different area of the washcloth for each eye. Gently wipe the eye from the nose side outward with the washcloth.
   c. If the eye has crusted material around it, wet a washcloth with warm water and place this over the eye.
   d. Wait about 1 minute.
   e. Gently wipe the eye from the nose side outward with the washcloth.
   f. Place it on the eye and wait again.
   g. If you cannot remove the crusting rewet the washcloth. Then try to gently remove the crusted drainage. Continue until all of the crusting is removed.
   h. If both eyes need cleaning, use separate cloths for each eye. Launder the cloths before using again.
   i. Remove and discard gloves.
   j. Wash hands.
3. Position the child.
   a. Lay down child on his/her back on a flat surface.
   b. If the child will not lie still place the child on her back, head between your legs, and arms under your legs.
   c. If needed, gently cross your lower legs over the child's legs to keep him/her from moving.
   d. Place a pillow under the child's shoulders or a rolled up towel under his neck so that his head is tilted back.
   e. Ask the child to tilt his/her head back and up.



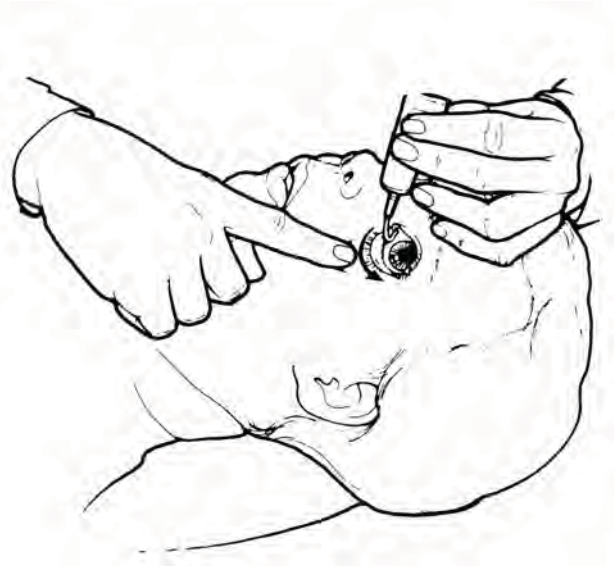
Continued

4. Apply eye ointment or eye drops.

Eye Drops	Eye Ointment
a. Bring refrigerated meds to room temperature. Rub the medicine bottle between the palms of your hands to warm the drops. b. Shake if label instructs you to do so. c. Tell the child to look up and to the other side. The eye drops should flow away from the child's nose. d. Place the wrist of the hand you will be using to give drops on the child's forehead. e. Bring the dropper close (within 1 inch) of the eye. f. Drop medicine in the lower eyelid away from the tear ducts, which are located in the lower inner corner of the eye.	a. Tell the child to look up and to the other side. The eye ointment should flow away from the child's nose. b. Place the wrist of the hand you will be using to give ointment on the child's forehead. c. Pull down slightly and gently on the skin below the eye, just above the cheekbone. d. Bring the tube close (within 1 inch) of the eye. e. Apply a thin line of ointment along the lower eyelid. f. Rotate the tube when you reach the edge of the outer eye, this will help detach the ointment from the tube.



Dropper and hand position for administering eye drops.



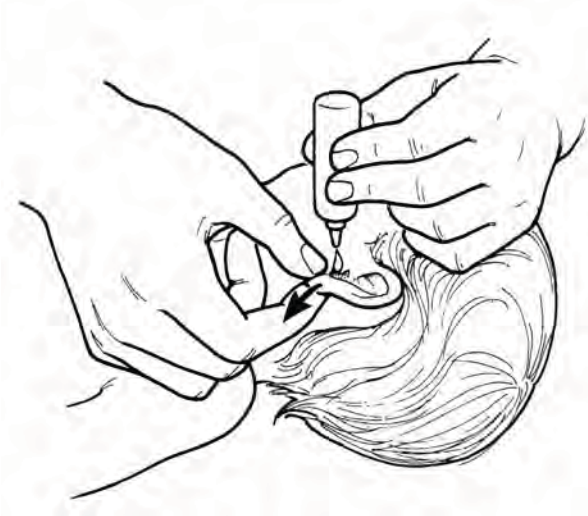
Tube and hand position for administering eye ointment.

5. Ask the child to close or blink his/her eyes for a minute to allow the eye drops or ointment to be dispersed throughout the eye.
6. Wipe excess medication or tearing with a clean tissue.
7. Rinse the dropper with water OR wipe the tip of the ointment tube with a clean tissue.
8. Replace the dropper to the bottle OR the cap on the tube immediately after each use.
9. Wash hands and document medication administration.

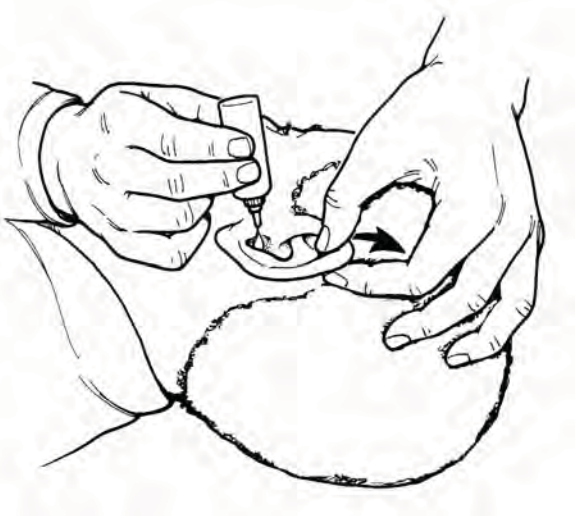
Ear Medication: Ear Drops

1. Wash hands and child's hands.
2. Rub the medicine bottle between the palms of your hands or place in warm water to warm the drops.
3. Feel a drop to make sure drops aren't too hot or too cold.
4. Ask the child to lie down or sit with the affected ear facing up.
5. Observe for any discharge (thick yellow or green substance), pus (cloudy), or blood. (If there is any, do not give medicine and report to parent/guardian.)
6. If there is drainage (clear liquid) remove it with a clean tissue or cotton tipped applicator. Do NOT clean any more than the outer ear.
7. Place the wrist of the hand you will be using to give medicine on the cheek or head.
8. Place the dropper/nozzle above the child's ear canal.

For children UNDER 3 years of age:	For children OVER 3 years of age:
a. Gently pull the outer flap of the affected ear DOWNWARD and backward to straighten the ear canal.	a. Gently pull the outer flap of the affected ear UPWARD and backward to straighten the ear canal.
b. Look for ear canal to open.	b. Look for ear canal to open.



Hand and dropper position for children 3 years old and younger with earlobe pulled down and back.



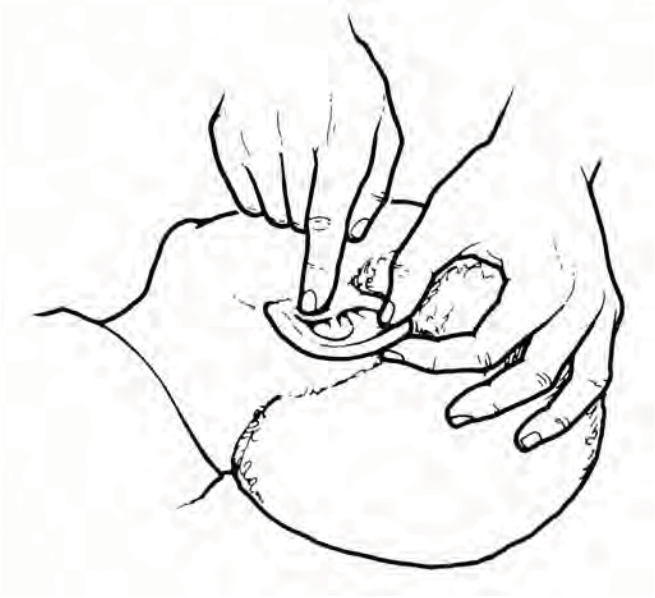
Hand and dropper position for children older than 3 years, with earlobe pulled up and back.

Continued

9. Squeeze the dropper slowly and firmly to release the appropriate amount of medicine on the side of the ear canal.

10. Ask the child to remain lying down for about 1-2 minutes so the medicine will be absorbed.

11. Gently rub the skin in front of the ear to help the drug flow to the inside of the ear.



Rubbing ear to help drug flow to inside of ear.

12. Place a cotton ball in the child's affected ear to avoid leakage of the medicine. Replace the cotton ball each time the medicine is given. Avoid inserting q-tips® into the ear.

13. Rinse the dropper tip in water after each use before capping or returning it to the bottle.

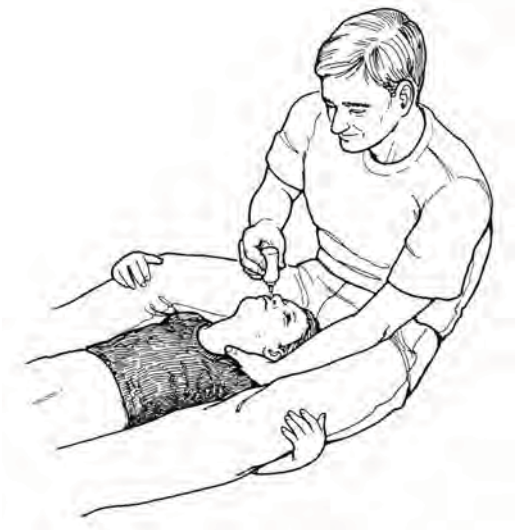
14. Replace the cap immediately after each use.

15. Wash hands and document medication administration.

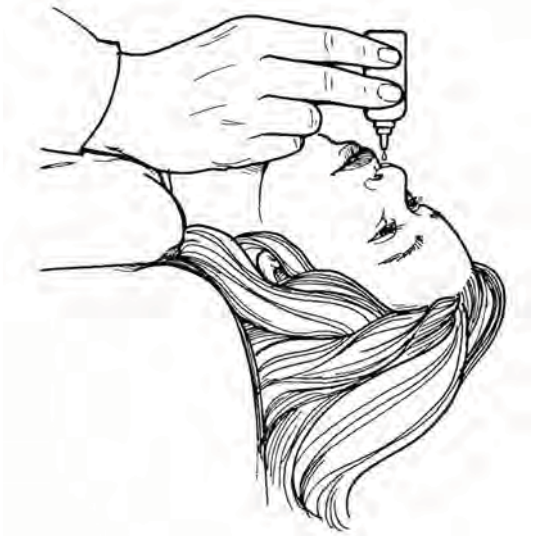
Nasal Medication

1. Wash hands and child's hands.
2. Remove any mucous from the nose with a clean tissue.
    a. Put on gloves.
    b. Ask the child to blow his/her nose.
    c. If the nose has crusted material around it, wet a washcloth or paper towel with with warm water and place this around the nose.
    d. Wait 1 minute.
    e. Gently wipe the nose with the washcloth or paper towel.
    f. If you cannot remove the crusting, rewet the cloth and again place it around the nose. Continue using the warm, moist washcloth and gently wiping until all of the crusting is removed.
    g. If using cloths, launder before using it again
3. Position the child.

Nasal Drops	Nasal Sprays
a. Ask the child to lie down on his back. b. Ask the child to tilt his/her head back slightly. c. Place a pillow or rolled-up towel under the child's shoulders or let the head hang over the side of a bed or your lap. o If the child will not lie still you hold the child by sitting on a flat surface, such as the floor or bed. o Place the child on her back with her head between your legs and her arms under your legs. o If needed, gently cross your lower legs over the child's legs to keep her from moving.	a. Ask the child to stand up and hold his/her head straight up and close mouth. b. Tell child to hold one nostril shut.



Safely holding child while giving nose drops.



Correct position of child's head and neck for giving nose drops.

Continued

4. Give medicine one side at a time.
5. Insert the tip of the nozzle into one of the child's nostrils.
6. Squeeze slowly and firmly to release the appropriate amount of medicine.
7. Insert the tip of the nozzle into the child's other nostril.
8. Squeeze slowly and firmly to release the appropriate amount of medicine.
9. Ask the child to remain lying down for about 1-2 minutes so the medicine will be absorbed. (NASAL DROPS ONLY)
10. Rinse the nozzle tip in water or wipe it with a clean tissue after each use before returning it to the bottle.
11. Replace the cap on the bottle immediately after each use.
12. Remove and discard gloves.
13. Wash hands and document medication administration.

Note: For nasal drops only

Before administering medications, use a bulb syringe to remove mucous.

a. Squeeze the bulb.
b. Put the tip gently into child's nostril.
c. Let go aspirating mucous from the nose.
d. Be careful because overuse of this tool can be irritating.
e. Clean the bulb syringe properly.

MODULE 4
Documentation

- Medication Administration Packet
- Recording information
- Making and recording observations




MODULE 4
Documentation

- Medication Administration Packet
- Recording information
- Making and recording observations

Medication Administration Packet

Previously Completed:

- Authorization to Give Medicine
- Receiving Medication

Need to Fill Out:

- Medication Log

Medication Administration Packet: Medication Log

- Completed by staff who administered the medication
- Includes:
  - Name of child
  - Medication
  - Day, time, dose, route, and staff signature
  - Reported errors or mishaps
  - Return or disposal of medication
- For “as needed” medication, write the reason the medication was given

Medication Administration Packet: Medication Log, continued

- Each child should have his or her own log
- Every dose of medication must be recorded to prevent dosing errors
- Recording takes place right after the medication is given
- Having a record helps to track and prove your actions
- Record unusual circumstances
- The log is a permanent record: legal document

Medication Administration Packet: Medication Log, continued

- Always write legibly and in INK
- Do not use white out, etc.
- For recording errors: cross out with single line, make correction and initial
- Fill in ALL blanks (indicate “N/A” if not applicable)
- Sign with a witness if necessary
- Records need to be kept for as long as your state requires them to be kept
- Parents should be able to get a record of medication given

Observations

- Make notations of possible side effects of the medication in the log
- Record incidents, such as child refusing to take medication
- Note successful techniques that helped the child to cooperate

Side effects and incidents will be discussed in the next module in more detail

Recording the Dose of Medication Activity

Recording the Dose of Medication Activity, continued

Recording the Dose of Medication, Nick

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Nick Sample Weight of child 95 lbs

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine	Amoxicillin				
Date	X/X/20xx	/ /	/ /	/ /	/ /
Actual time given	AM ____ PM 12:00	AM ____ PM	AM ____ PM	AM ____ PM	AM ____ PM
Dosage/amount	One teaspoon				
Route	By Mouth				
Staff signature	C. Staff				

Recording the Dose of Medication Activity, continued

Recording the Dose of Medication, Maria

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Maria Test Weight of child 30 lbs

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine	Hydrocortisone Cream 1%				
Date	X/X/20xx	/ /	/ /	/ /	/ /
Actual time given	AM ____ PM 1:05	AM ____ PM	AM ____ PM	AM ____ PM	AM ____ PM
Dosage/amount	Thin Layer				
Route	on skin				
Staff signature	C. Staff				

Group Activity: Recording the Dose of Medication: Nick

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

Group Activity: Recording the Dose of Medication: Maria

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

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RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

MODULE 5

Problem Solving

- Medication errors
- Medication side effects
- Medication incidents
- What to do for problems and how to document them
- Field trips
- Self administration
- Problems with requests

MODULE 5
Problem Solving

- Medication errors
- Medication side effects
- Medication incidents
- What to do for problems and how to document them
- Field trips
- Self administration
- Problems with requests

Communication and Care

- Preventing errors begins with good communication on drop-off and pick-up

What is a Medication Error?

- Giving the medication to the **wrong child**
- Giving the **wrong medication**
- Giving the **wrong dose**
- Giving the medication at the **wrong time**
- Giving the medication by the **wrong route**

…any of the "5 Rights" gone wrong…

Preventing Medication Errors

- Look at the pattern of errors
- Make changes based on the patterns seen to prevent further errors of that type
  - A common error is forgetting to give a dose of medication
  - Set an alarm to remind you that it is time to administer a medication
- *Can you think of other ways to prevent errors?*

Side Effects of Medication

- A secondary and usually adverse effect of taking a medication
- Common side effects include:
  - Upset stomach
  - Diarrhea or loose stools
  - Dry mouth
  - Drowsiness
  - Change in activity or mood
  - Dizziness
  - Flushing, sweating
  - Rashes
  - Rapid heartbeat
  - Nausea

Side Effects of Medication, continued

- Effects of medication can vary from child to child
  - The same antihistamine (diphenhydramine/Benadryl®) can make one child sleepy while another becomes jittery and hyperactive
- Side effects that could be normal for 1 medication might be abnormal for another
  - Fast heart rate is expected for albuterol, an asthma medication, but not for a fever reducing medication

Sources of Information About Medication Side Effects

- Package inserts or labels
- Information from pharmacy
- Information from the prescribing health care professional
- The child's health assessment or care plan completed by the health care professional
- Reliable reference materials like the PDR (Physician's Desk Reference)
- www.consumermedsafety.org

Adverse Effects or Allergic Reactions to Medication

Adverse Effect

- Any undesirable experience associated with the use of a medical product in a patient

Allergic Reactions

- May involve many different types of symptoms
- Are difficult to predict
- Skin disturbances are the most common
- May be mild (redness of skin, itching)
- May be severe (life threatening)

Observation

Young children can't always verbalize side effects, adverse effects, or allergic reactions, so **careful observation** is essential

Medication Incidents (that aren't errors…)

- Child refusal
- Spit out doses
- Vomited doses
- Spilled medication

What To Do for Medication Errors, Adverse Effects, or Allergic Reactions

Always:
- If the child is in distress, call 911
- Notify the center director (if this is a serious error, do not delay the 911 call)
- Notify parent or guardian
- Fill out a Medication Incident Report

Many times you will:
- Call Poison Control
- Contact the health care professional
- Check with the Child Care Health Consultant, if available
- Notify state Bureau of Licensing

What To Do for Medication Incidents?

Always:
- Notify the center director
- Notify parent/guardian
- Fill out a Medication Incident Report
- Develop and document a follow-up plan

Many times (depending on the situation):
- Contact the health care professional and Child Care Health Consultant

Never:
- Repeat a dose that the child does not keep down without specific instructions from a health care professional

When Should You Call 911?

- When you see signs of distress
- When there is a loss of (or change in) consciousness
- Blue color or difficulty breathing
- Difficulty swallowing
- Swelling of lips, tongue, or face, or drooling
- Seizure activity
- Rapidly spreading rash or hives
- Impaired speech or mobility
- Getting worse quickly
- When in doubt

When Should You Call Poison Control? 1-800-222-1222

- When medication is given to the wrong child
- When the wrong medication is given to a child
- When the wrong dose is given (overdose)
- When a medication is given by the wrong route
- When a medication is given at the wrong time (and it results in an extra dose)

The AAP no longer recommends that syrup of ipecac be used

If You Call Poison Control

Have this information ready:

- The medication container
- Child's Medication Administration Packet
- Child's Emergency Contact Form
- Child's current weight

Medication Incident Report

- To be completed by the person who administered the medication or his or her supervisor

Documentation of an Error or Incident

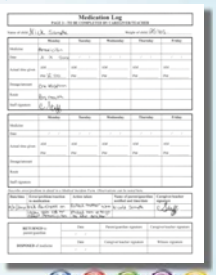
- Make notation on the Medication Log for that dose
- Complete Medication Incident Report
- Follow up according to child care facility policy

Scenario: Nick

- You gave Nick his dose of amoxicillin at noon and recorded it. At 12:30, you note that Nick is scratching his arms and he is developing a rash on his arms. He is happy and playful and is not having any breathing difficulties. You notify his parent who calls his health care professional. Nick is picked up at 1:00 and is brought to the health care professional's office where he receives Benadryl®. His amoxicillin is discontinued and he is given a new antibiotic.

Scenario: Nick, continued


Medication Incident Report


Medication Log

Other Resources

- Child Care Health Consultants
- National Resource Center for Health and Safety in Child Care
  - *Caring for Our Children Standards*
  - *1-800-598-kids*
  - *http://nrckids.org*
- Local pharmacist
- Child's health care professional
- Local children's hospitals
- Other health educators

Transportation Provided by the Child Care Facility and Field Trips

- A staff person authorized to administer medication should be present when supervising a child outside of the child care facility grounds
- Medication should be properly secured and labeled
- The proper temperature and conditions for the medication should be maintained
- Copies of emergency contact information and the child's medical forms should be carried
- The dose of medication given outside of the facility must be properly logged, and any side effects should be noted
- Hand hygiene must be maintained
- Emergency contact methods (such as a cell phone) must be available

Self Administration

- For older children, it may be appropriate for them to carry and take their medication themselves
- Decisions about self administration should be based on:
  - Prescriber recommendation
  - Student factors
  - Parent or guardian factors
  - School or community factors
  - Local and state laws and regulations

Provider Refusal

- There may be an occasion when you must refuse to give medication because:
  - Special training is needed before administering medication
  - Required authorizations or other documentation is lacking
  - Parent makes inappropriate request
  - It is against facility policy

Inappropriate Requests

- Non-essential medication
- Medication not authorized by a health care professional
- Off-label use
- Cough and cold medications for young children

Child Care Provider Refusal Options

- Have your medication administration policy available
  - The parent should have signed a copy of it upon enrollment
- Take a problem-solving, child-centered approach
- Seek alternative plans like having a nurse or parent come to administer the medication
- See if medication timing can be changed to avoid a dose during hours of care
- Consider obtaining special staff training, if appropriate

Responding to Parents/Guardians

"I do understand, but for the safety of your child and the other children in our setting…"

"I am sorry, but according to our policy…"

What to Do?

- Call your supervisor
- Ask the parent to make alternative arrangements
- Record the situation and document the response

Wrap Up

- Post-test
- Additional Resources
- Certificate of Attendance

Congratulations!

"The level of civilization attained by any society will be determined by the attention it has paid to the welfare of its children."

B. Andrews, 1968,
The Children's Bill of Rights

Group Activity: Problems with Nick

You gave Nick his dose of amoxicillin at noon and recorded it. At 12:30, you note that Nick is scratching his arms and he is developing a rash on his arms. He is happy and playful and is not having any breathing difficulties. You notify his parent who calls his health care professional. Nick is picked up at 1:00 and is brought to the health care professional's office where he receives Benadryl®. His amoxicillin is discontinued and he is given a new antibiotic.

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

Group Activity: Problems with Nick

Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

_____

_____

_____

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature _____

Adapted with permission from Healthy Child Care Colorado.

Optional Group Activity: Problems with Maria

Maria refuses her medication saying it burns her. What do you do?

Optional Group Activity: Problems with Maria

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

Optional Group Activity: Problems with Maria

Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

_____

_____

_____

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature _____

Adapted with permission from Healthy Child Care Colorado.

Optional Flip Chart Activity: Identifying Medication Errors

News Story

November 3, 1998

An assistant director gave medicine to a teacher who admitted she did not read the label on the medicine until after she put the drops in the child's eyes at about 1 pm, the notice states. When she realized she had put eardrops in a child's eyes, she notified the assistant director about what happened. She said the assistant director dismissed the incident and said it was no big deal, the notice states. Only after the 4-year-old's mother noticed that his eyes were red and swollen was he taken to the emergency room at UNC hospitals and then treated in the hospital's eye care center. It is unclear how badly he was injured, though he can still see. The center's history of problems, along with the eardrops incident in June, led to the revocation, said Talitha Wright, chief of regulatory services with the Division of Child Development. "It's pretty significant when someone puts eardrops into a child's eyes, and when the medicine wasn't even meant for that child," she said.

Sources: Price J. State pulls child-care center's license for second time. *The Chapel Hill News*. November 3, 1998.

Velliquette, B. KinderCare's license revoked. *The Chapel Hill Herald*. November 3, 1998.

Name State Date

Medication Administration in Child Care Post-test

Instructions: Circle the letter of the choice that best completes the statement or answers the question. If select modules were presented, only fill out the questions related to those modules.

MODULE 1

1. The Americans with Disabilities Act states that a reasonable accommodation includes:

a. Giving medication ONLY if the child care facility receives federal funding
b. Giving medication to children with ongoing special health needs
c. Admitting a child with special health care needs but not giving medication
d. None of the above

2. Medication available without a health care professional's note or pharmacy label is called:

a. Prescription medication
b. Over-the-counter (OTC) medication
c. Non-toxic medication
d. None of the above

3. Matching: In the blanks next to each definition below, enter the number of the word that corresponds to the definition.

Word List	Definitions	
1. Oral	_____	Medication that is administered by breathing it into the respiratory system (for example, a mist or spray medication)
2. Topical	_____	Medication in lotion, cream, ointment, spray, or other form for external application for skin or other medical problems
3. Inhalation	_____	Form of medication that is inserted into the rectum
4. Injectable	_____	Medication that is put into the mouth such as tablets, capsules, and liquid medication
5. Suppository	_____	Medication that is put into the body with a needle or other device that rapidly puts the medication through the skin surface, such as the EpiPen®, Glucagon®, and insulin.

Module 2

4. **Your facility policy should include all of the following:**
   a. Who will administer medication and who the alternate person will be
   b. What medication will be given
   c. Where and how medication will be stored
   d. Procedure for medication error or incident
   e. All of the above

5. **A mother brings in some chewable tablets that she took from a bottle of medication that she says her daughter's health care professional prescribed the day before. The mother is keeping the main supply of the medication at home. She fills out the program forms to give permission to the staff to give the medication at noon to her child. What is the most appropriate thing for the child care provider to do?**
   a. Call the health care professional immediately to see if it is okay to give the medication
   b. Give the medication to the child if it looks/smells okay
   c. Refuse to give the medication
   d. Don't know

6. **When receiving a medication you should:**
   a. Match the label with permissions and instructions
   b. Ask the parent/guardian about successful techniques that he has used to administer the medication
   c. Ask the parent/guardian about when the medication was last administered
   d. All of the above

7. **A guardian brings you medication for her child. After receiving the medication, your next step should be to:**
   a. Sort the medication for ease of delivery
   b. Log in medication and store it
   c. Administer the medication within the next 3 hours
   d. Don't know

8. **All of the following are steps in the process of receiving medications EXCEPT:**
   a. Match the label with the instructions
   b. Check if container is labeled child-resistant
   c. Check expiration date
   d. Ensure that the child receives a dose that same day

Name State Date

Module 3

9. Ways to tell if you have the Right child include all of the following EXCEPT:

a. Knowing the child from your experience
b. Asking the child if she is the name that appears on the label
c. Having a photo of the child attached to the medication administration paperwork
d. Having another staff member who is familiar with the child verify her identity

10. Administering the Right dose of medication involves all of the following EXCEPT:

a. Checking the label and the permission form to see if they match.
b. Using a measuring device
c. Verifying the dose with the child
d. Checking the measuring device at eye level

11. Which of the following is an example of an "as needed medication"?

a. Tylenol® for fever
b. Albuterol® for wheezing
c. Amoxicillin for ear infection
d. A and B
e. All of the above

12. A child refuses to take her medication. In order to get the child to comply, you consider mixing the medication with her favorite beverage. Before doing so you should:

a. Split the medication into 2 doses to ensure that the child takes her full dosage
b. Check with the health care professional or pharmacist before mixing medications with food or beverages
c. Give the child a small portion of the beverage prior to mixing the medication into it
d. None of the above

13. A young toddler in your care is refusing to take a dose of antibiotic. You should:

a. Mix it in the child's bottle
b. Hold his nose until he opens his mouth
c. Refuse to give the child the medication
d. Give the child the choice of what drink he wants after taking the medication

Name State Date

Module 4

14. Please read the scenario and enter the information into the medication log below.

Scenario: Today, you give Nick one 125 mg capsule of Depakote® sprinkles at 12:00 PM.

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Name State Date

Module 5

15. Upset stomach, diarrhea, dry mouth, changes in mood, and drowsiness after taking a medication are all examples of:

a. Effective medication
b. Medication errors
c. Side effects
d. Overdose of medication

16. When calling Poison Control, you should have which of the following information available?

a. The medication container
b. The child's current weight
c. The child's Emergency Contact Form
d. All of the above
e. None of the above

17. In which of the following situations should Poison Control be called:

a. The child refuses to take his medication
b. You give the wrong medication to a child
c. You give a medication to the wrong child
d. B and C

18. A child takes his medication in his mouth and then spits it out. What actions should be performed?

a. Notify the parent/guardian
b. Repeat the dose
c. Fill out a medication incident report
d. A and C
e. All of the above

19. It is 2:00 PM and you realize that you forgot to give a dose of medication that was due at 12:00 PM. The first thing you should do is:

a. Give the dose right away
b. Document the missed dose and notify the parent
c. Contact the child's doctor
d. Contact the pharmacist's advice

Name State Date

Additional Resources

- Glossary
- Emergency Information Form for Children with Special Needs
- Asthma Action Plan, for Children 0–5 Years
- Asthma Action Plan, for Children 6 Years or Older
- Care Plan for Children with Special Health Needs
- Instructions for Completing the Care Plan for Children with Special Health Needs
- Information Exchange on Children with Health Concerns Form
- Consent for Release of Information Form
- Daily Log of Controlled Medications Administered
- Medication Administration Packet
- Medication Incident Report
- Washing Your Hands
- Handwashing
- Dear Parents/Guardians Letters
- Questions and Answers: IDEA and Child Care
- When Should Students with Asthma or Allergies Carry and Self Administer Emergency Medications at School?
- EpiPen® Resources
- Candy or Medicine? — Look Alike Drugs
- Look Alike Products — Don't Be Fooled
- Certificate of Attendance





Glossary

These definitions are adapted from American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs.* 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Available at: http://nrckids.org/CFOC/index.html. Accessed June 24, 2009

AAP: Abbreviation for the American Academy of Pediatrics, a national organization of pediatricians founded in 1930 and dedicated to the improvement of child health and welfare.

Acute: Adjective describing an illness that has a sudden onset and is of short duration.

Allergen: A substance (eg, food, pollen, pets, mold, medication) that causes an allergic reaction.

Anaphylaxis: An allergic reaction to a specific allergen (eg, food, pollen, pets, mold, medication) that causes dangerous and potentially fatal complications, including swelling and closure of the airway that can lead to an inability to breathe.

Antibiotic prophylaxis: Antibiotics that are prescribed to *prevent* infections in infants and children in situations associated with an increased risk of serious infection with a specific disease. Usually prescribed in a low dose over a long period.

APHA: Abbreviation for the American Public Health Association, a national organization of health professionals that protects and promotes the health of the public through education, research, advocacy, and policy development.

Bleach solution: For sanitizing environmental surfaces—use a spray solution of a quarter (¼) cup of household liquid chlorine bleach (sodium hypochlorite) in 1 gallon of water, prepared fresh daily. Where blood contamination is likely, the concentration of bleach solution should be increased to 1 part bleach to 10 parts water because if hepatitis B virus is present in the blood, this higher concentration of bleach is required to kill it. See also *Disinfect.*

Body fluids: Urine, feces, saliva, blood, nasal discharge, eye discharge, and injury or tissue discharge.

Care Plan: A document that provides specific health care information, including any medications, procedures, precautions, or adaptations to diet or environment that may be needed to care for a child with chronic medical conditions or special health care needs. Care Plans also describe signs and symptoms of impending illness and outline the response needed to those signs and symptoms. A Care Plan is completed by a health care professional and should be updated on a regular basis.

Caregiver: Used in this book to indicate the primary staff who work directly with children in child care centers, small or large family child care homes, or schools (ie, director, teacher, aide, child care provider, or those with other titles or child contact roles).

Catheterization: The process of inserting a hollow tube into an organ of the body, for an investigative purpose or to give some form of treatment (eg, remove urine from the bladder of a child with neurologic disease).

CDC: Abbreviation for the Centers for Disease Control and Prevention, which is responsible for monitoring communicable diseases, immunization status, injuries, and congenital malformations, and performing other disease and injury surveillance activities in the United States.

Center: A facility that provides care and education for any number of children in a nonresidential setting and is open on a regular basis (it is not a drop-in facility).

Children with special health care needs: Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Chronic: Adjective describing an infection or illness that lasts a long time (months or years).

Clean: To remove dirt and debris (eg, blood, urine, feces) by scrubbing and washing with a detergent solution and rinsing with water.

CPR: Abbreviation for cardiopulmonary resuscitation, emergency measures performed by a person on another person whose breathing or heart activity has stopped. Measures include closed-chest cardiac compressions and mouth-to-mouth ventilation in a regular sequence.

Disinfect: To eliminate virtually all germs from inanimate surfaces by using chemicals (eg, products registered with the US Environmental Protection Agency as "disinfectants") or physical agents (eg, heat).

Educator: A teacher or caregiver who is professionally responsible for the education of the children who are placed in his or her care.

Emergency response practices: Procedures used to call for emergency medical assistance, reach parents or emergency contacts, arrange for transfer to medical assistance, and render first aid to the injured person.

Exclusion: Denying admission of an ill child or staff member to a facility or asking the child or staff member to leave if present.

Facility: A legal definition of the buildings, grounds, equipment, and people involved in providing child care or education of any type.

Febrile: The condition of having an abnormally high body temperature (fever), often as a response to infection.

Fever: An elevation of body temperature. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, inflammatory conditions (eg, arthritis, lupus), cancers, and response to infection. For this purpose, fever is defined as temperature above 101°F (38.3°C) orally, above 102°F (38.9°C) rectally, or of 100°F (37.8°C) or higher taken axillary (armpit) or measured by any equivalent method. Fever is an indication of the body's response to something, but is neither a disease nor a serious problem by itself.

Gastric tube feeding: The administration of nourishment through a tube that has been surgically inserted directly into the stomach.

Gestational: Occurring during or related to pregnancy.

Gross-motor skills: Large movements involving the arms, legs, feet, or entire body (eg, crawling, running, jumping).

Group care setting: A facility where children from more than one family receive care together.

Health care professional: Someone who practices medicine with or without supervision, and who is licensed by an established body. The most common types of health care professionals include physicians, nurse practitioners, nurses, and physician assistants.

Health consultant: A physician, a certified pediatric or family nurse practitioner, a registered nurse, or an environmental, an oral, a mental health, a nutrition, or another health professional who has pediatric and child care experience and is knowledgeable in pediatric health practice, child care, licensing, and community resources. The health consultant provides guidance and assistance to child care staff on health aspects of the facility.

HIV: Abbreviation for human immunodeficiency virus.

Immunity: The body's ability to fight a particular infection. Immunity can come from antibodies (immune globulin), cells, or other factors.

Immunizations: Vaccines that are given to children and adults to help them develop protection (antibodies) against specific infections. Vaccines may contain an inactivated or a killed agent, part of the agent, an inactivated toxin made by an agent (toxoid), or a weakened live organism.

Individualized Education Program (IEP): A written document, derived from Part B of the Individuals With Disabilities Education Act, that is designed to meet a child's individual educational program needs. The main purposes of an IEP are to set reasonable learning goals and state the services that the school district will provide for a child with special educational needs. Every child who is qualified for special educational services provided by the school is required to have an IEP.

Individualized Family Service Plan (IFSP): A written document, derived from Part C of the Individuals With Disabilities Education Act, that is formulated in collaboration with the family to meet the needs of a child with a developmental disability or delay; assist the family in its care for a child's educational, therapeutic, and health needs; and deal with the family's needs to the extent to which the family wishes assistance.

Infant: A child between the time of birth and 12 months of age.

Infection: A condition caused by the multiplication of an infectious agent in the body.

Lead agency: Refers to an individual state choice for the agency that will receive and allocate federal and state funding for children with special educational needs. Federal funding is allocated to individual states in accordance with the Individuals With Disabilities Education Act.

Source: Excerpted from the American Academy of Pediatrics. Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide. Donoghue EA, Kraft CA. eds. Elk Grove Village, IL: American Academy of Pediatrics; 2009

Lethargy: Unusual sleepiness or low activity level.

Mainstreaming: A widely used term that describes the philosophy and activities associated with providing services to persons with disabilities in community settings, especially in school programs, where such children or other persons are integrated with persons without disabilities and are entitled to attend programs and have access to all services available in the community.

Medications: Any substances that are intended to diagnose, cure, treat, or prevent disease, or affect the structure or function of the body of humans or other animals.

Nasogastric tube feeding: The administration of nourishment using a plastic tube that stretches from the nose to the stomach.

Nonprescription medications: Drugs that are generally regarded as safe for use if the label directions and warnings are followed. Nonprescription medications are also called over-the-counter drugs because they can be purchased without a prescription from a health care professional. Foods or cosmetics that are intended to treat or prevent disease or affect the functions of the human body (eg, suntan lotion, fluoride toothpaste, antiperspirant deodorants, antidandruff shampoo) are also considered to be nonprescription medications.

Occupational therapy: Treatment based on the use of occupational activities of a typical child (eg, play, feeding, toileting, dressing). Child-specific exercises are developed to encourage a child with mental or physical disabilities to contribute to his or her own recovery and development.

OSHA: Abbreviation for the Occupational Safety and Health Administration of the US Department of Labor, which regulates health and safety in the workplace.

Parent: The child's natural or adoptive mother or father, guardian, or other legally responsible person.

Pediatric first aid: Emergency care and treatment of an injured child before definite medical and surgical management can be secured. Pediatric first aid includes rescue breathing and addressing choking.

Physical therapy: The use of physical agents and methods (eg, massage, therapeutic exercises, hydrotherapy, electrotherapy) to assist a child with physical or mental disabilities to optimize his or her individual physical development or restore his or her normal body function after illness or injury.

Prenatal: Existing or occurring before birth (as in prenatal medical care).

Primary care provider (PCP): The physician in the child's medical home who supervises the team that provides preventive care, routine illness care, and care coordination with the child's specialists and therapists.

Reflux: An abnormal backward flow of liquids. The term is commonly used to describe gastroesophageal reflux of stomach contents into the esophagus, or urinary reflux of urine from the bladder up toward the kidneys.

Rescue breathing: The process of breathing air into the lungs of a person who has stopped breathing. This process is also called artificial respiration.

Sanitize: To remove filth or soil and small amounts of certain bacteria. For an inanimate surface to be considered sanitary, the surface must be clean (see *Clean*) and the number of germs must be reduced to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfection (see *Disinfect*) and is applicable to a wide variety of routine housekeeping procedures involving, for example, bedding, bathrooms, kitchen countertops, floors, and walls.

Seizure: A sudden attack or convulsion caused by involuntary, uncontrolled bursts of electrical activity in the brain that can result in a wide variety of clinical manifestations, including muscle twitches, staring, tongue biting, loss of consciousness, and total body shaking.

Staff: Used here to indicate all personnel employed at the child care facility or school, including caregivers, teachers, and personnel who do not provide direct care to children (eg, cooks, drivers, housekeeping personnel).

Source: Excerpted from the American Academy of Pediatrics. Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide. Donoghue EA, Kraft CA. eds. Elk Grove Village, IL: American Academy of Pediatrics; 2009

Standard precautions: Techniques used to protect a person when there is contact with non-intact skin, mucous membranes, blood, all body fluids, and excretions except sweat. The general methods of infection prevention are indicated for all people in the group care setting and are designed to reduce the risk of transmission of microorganisms from recognized and unrecognized sources of infection. Although standard precautions were designed to apply to hospital settings, except for the use of masks and gowns, they also apply in group care settings. Standard precautions involve use of barriers (eg, gloves) as well as hand washing, and cleaning and sanitizing surfaces. Group care adaptation of standard precautions (exceptions from the use in hospital settings) are as follows:

- Use of nonporous gloves is optional except when blood or blood-containing body fluids may be involved.
- Gowns and masks are not required.
- Appropriate barriers include materials, such as disposable diaper table paper and disposable towels and surfaces, that can be sanitized in group care settings.

Substitute staff: Caregivers/teachers who are hired for one day or an extended period but are not considered permanent workers in their assigned positions.

Toddler: A child between the age of ambulation and toilet learning and training (usually between 13 and 35 months).

Universal precautions: A term used by OSHA that applies to protection against blood and other body fluids that contain blood, semen, and vaginal secretions, but not to feces, nasal secretions, sputum, sweat, tears, urine, saliva, and vomitus, unless they contain visible blood or are likely to contain blood. Universal precautions include avoiding injuries that are caused by sharp instruments or devices and the use of protective barriers, such as gloves, gowns, aprons, masks, or protective eyewear, that can reduce the risk of exposure of the worker's skin or mucous membranes that could come in contact with materials that may contain blood-borne pathogens while the worker is providing first aid or care.

Source: Excerpted from the American Academy of Pediatrics. Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide. Donoghue EA, Kraft CA. eds. Elk Grove Village, IL: American Academy of Pediatrics; 2009

Emergency Information Form for Children With Special Needs

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed By Whom	Revised	Initials
	Revised	Initials

Last name:

Name: Birth date: Nickname:

Home Address: Home/Work Phone:

Parent/Guardian: Emergency Contact Names & Relationship:

Signature/Consent*:

Primary Language: Phone Number(s):

Physicians:

Primary care physician: Emergency Phone:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Anticipated Primary ED: Pharmacy:

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1 . Baseline physical findings:

2.

3. Baseline vital signs:

4.

Synopsis:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

SAMPLE ASTHMA ACTION PLAN

Asthma Action Plan, for Children 0–5 Years

Name _____

DOB _____

Record # _____

Health Care Provider's Name _____

Health Care Provider's Phone Number _____ Completed by _____ Date _____

Long-Term Control Medicines (Use every day to stay healthy)	**How Much To Take**	**How Often**	**Other Instructions** (such as spacers/masks, nebulizers
		_____ times per day EVERY DAY	
		_____ times per day EVERY DAY	
		_____ times per day EVERY DAY	

Quick-Relief Medicines	**How Much To Take**	**How Often**	**Other Instructions**
		Give ONLY as needed	NOTE: If this medicine is needed often (_____ per week), call physician

GREEN ZONE

Child is WELL and has no asthma symptoms, even during active play

Prevent asthma symptoms every day

- **Give the above long-term control medicines every day**
- Avoid things that make the child's asthma worse
- ☑ Avoid tobacco smoke, ask people to smoke outside
- ☐ _____
- ☐ _____

YELLOW ZONE

Child is NOT WELL and has asthma symptoms that may incude:

- Coughing
- Wheezing
- Runny nose or other cold symptoms
- Breathing harder or faster
- Awakening due to coughing or difficulty breating
- Playing less than usual
- _____
- _____

Other symptoms that could indicate that your child is having trouble breathing may include: difficulty feeding (grunting sounds, poor sucking), changes in sleep patterns, cranky and tired, decreased appetite

CAUTION: Take action by continuing to give regular asthma medicines **every day AND:**

☐ Give _____

_____ (include dose and frequency)

If the Child is not in the *Green Zone* and still has symptoms after 1 hour:

☐ Give _____

_____ (include dose and frequency)

☐ Give _____

_____ (include dose and frequency)

☐ Call _____

RED ZONE

Child FEELS AWFUL warning signs may incude:

- Child's wheeze, cough or difficult breathing continues or worsens, even after giving yellow zone medicines
- Child's breathing is so hard that he/she is having trouble walking/talking/eating/playing
- Child is drowsy or less alert than normal

DANGER!

Get help immediately! Call 9-1-1 if:

MEDICAL ALERT! Get help!

☐ Take the child to the hospital or call 9-1-1 immediately!

☐ Give more _____

_____ (include dose and frequency) until you get help

☐ Give more _____

_____ (include dose and frequency) until you get help

- **The child's skin is sucked in around neck and ribs or**
- **Lips and/or fingernails are grey or blue, or**
- **Child doesn't respond to you.**

Source: http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan. http://www.rampasthma.org

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:118.

Patient Name _____ DOB _____

Asthma Action Plan, for Children 0–5 Years, *continued*

PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Children ages 0-5)

- ☐ **Determine the Level of Asthma severity** (see Table 1)
- ☐ **Fill In Medications**
  Fill in medications appropriate to that level (see Table 1) and include instructions, such as "shake well before using" "use with spacer", and "rinse mouth after using".
- ☐ **Address Issues Related To Asthma Severity**
  These can include allergens, smoke, rhinitis, sinusitis, gastro-esophaegeal reflux, sulfite sensitivity, medication interactions, and viral respiratory infections.
- ☐ **Fill in and Review Action Steps**
  Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help.
- ☐ **Distribute copies of the plan**
  Give the top copy of the plan to the family, the next one to school, day care, caretaker, or other involved third party as appropriate, and file the last copy in the chart.
- ☐ **Review Action plan Regularly (Step Up/Step Down Therapy)**
  A patient who is always in the green zone for some months may be a candidate to "step down" and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient should "step up" to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

TABLE 1 SEVERITY AND MEDICATION CHART (Classification is based on meeting at least one criterion)

	Severe Persistent	Moderate Persistent	Mild Persistent	Mild Intermittent
Symptoms/Day	Consistent symptoms	Daily symptoms	> 2 days/week but < 1 time/day	≤ 2 days/week
Symptoms/Night	Frequent	> 1 night/week	> 2 nights/month	≤ 2 nights/month
Long Term Control[1]	**Preferred treatment:** • Daily *high-dose* inhaled corticosteroid **AND** • Log acting inhaled B_2 – agonist **AND, if needed:** • Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.) ***Consultation With Asthma Specialist Recommended***	**Preferred treatment:** • Daily *low dose* inhaled corticosteroid and long-acting inhaled B_2 – agonist OR • Daily *medium-dose* inhaled corticosteroid **Alternative treatment:** • Daily *low-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline **If needed** (particularly in patients with recurring severe exacerbations): **Preferred treatment:** • Daily *medium dose* inhaled corticosteroid and long-acting inhaled B_2 – agonist **Alternative treatment:** • Daily *medium-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline ***Consultation With Asthma Specialist Recommended***	**Preferred treatment:** • Daily *low dose* inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI) **Alternative treatment:** • Cromolyn (nebulizer is preferred or MDI with holding chamber) **OR** • Leukotriene receptor antagonist **Note:** Initiation of long-term controller therapy should be considered if child has had more then three episodes of wheezing in the past year that lasted more than one day and affected sleep and who have risk factors for the development of asthma[2] ***Consultation With Asthma Specialist Recommended***	**NO** daily medication needed.
Quick Relief[1]	**Preferred treatment:** • Inhaled short-acting B_2 – Agonist **Alternative treatment:** • Oral B_2 – agonist	**Preferred treatment:** • Inhaled short-acting B_2 – Agonist **Alternative treatment:** • Oral B_2 – agonist	**Preferred treatment:** • Inhaled short-acting B_2 – Agonist **Alternative treatment:** • Oral B_2 – agonist	**Preferred treatment:** • Inhaled short-acting B_2 – Agonist **Alternative treatment:** • Oral B_2 – agonist

[1] For infants and children use spacer or spacer AND MASK.

[2] Risk factors for the development of asthma are parental history of asthma, physician-diagnosed etopic dermatitis or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia. With viral respiratory infection, use bronchodilator every 4-6 hours up to 24 hours (longer with physician consult); in general no more than once every six weeks. If patient has seasonal asthma on a predictable basis, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn) should be initiated prior to the anticipated onset of symptoms and continued through the season.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's. "Guidelines for the Diagnosis and Management of Asthma." NIH Publication No. 97-4051 (April 1997) and "Update on Selected Topics 2002." NIH Publication No. 02-5075 (June 2002).

Asthma Action Plan, for Children 6 Years or Older

Name _____

DOB _____

Record # _____

Health Care Provider's Name _____

Health Care Provider's Phone Number _____ Completed by _____ Date _____

Long-Term Control Medicines (Use every day to stay healthy)	How Much To Take	How Often	Other Instructions (such as spacers/masks, nebulizers
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	

Quick-Relief Medicines	How Much To Take	How Often	Other Instructions
		Take ONLY as needed	NOTE: If this medicine is needed frequently, call physician to consider increasing long-term-control medications

Special instructions when I feel ***good*** (green), ***not good*** (yellow), and **awful** (red).

GREEN ZONE

I feel ***good.***

(My **peak flow** is in the **GREEN** zone.)

Prevent asthma symptoms everyday

- ☐ Take my long-term-control medicines (above) every day
- ☐ Before exercise, take _____ puffs of _____
- ☐ Avoid things that make my asthma worse like:_____

YELLOW ZONE

I do ***not*** feel ***good.***

(My **peak flow** is in the **YELLOW** zone.)

My symptoms may include one or more of the following:

- Wheeze
- Tight chest
- Cough
- Shortness of breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities
- _____
- _____

CAUTION: I should continue taking my long-term-control asthma medicines every day AND**:**

- ☐ Take _____

If I do not feel good, or my peak flow is not in the *Green Zone* within 1 hour, then I should:

- ☐ Increase _____
- ☐ Add _____
- ☐ Call _____

RED ZONE

I feel ***awful***:

(My **peak flow** is in the **RED** zone.)

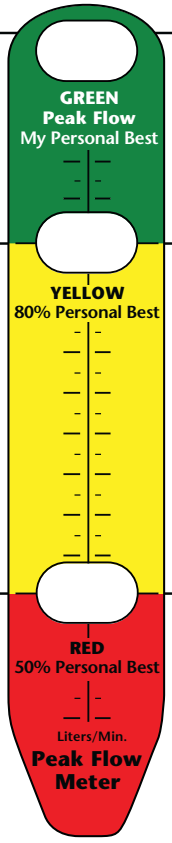
Warning signs may include one or more of the following:

- It's getting harder and harder to breathe.
- Unable to sleep or do usual activities because of trouble breathing.

DANGER!
Get help immediately!

MEDICAL ALERT! Get help!

- ☐ Take _____ until I get help immediately!
- ☐ Take _____
- ☐ Call _____



Call 9-1-1 if you have trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.

Source: Adapted and reprinted with permission from the Regional Asthma Management and Prevention (RAMP) initiative, a program of the Public Health Institute. http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan.
Source: http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan. http://www.rampasthma.org
Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:117.

Doctor _____ Doctor's Phone Number _____ .Date _____

Hospital/Emergency Department Phone Number _____

Asthma Action Plan, for Children 6 Years or Older, *continued*

Patient Name _____ DOB _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term-control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____

Identify and avoid and control the things that make your asthma worse, like (list here):

_____ _____ _____

_____ _____ _____

Before exercise, if prescribed , take: ☐ 2 or ☐ 4 puffs _____ 5 to 60 minutes before exercise

YELLOW ZONE

ASTHMA IS GETTING WORSE.

- Cough, wheeze, chest tightness or shortness of breath, or
- Waking at night due to asthma or
- Can do some but not all usual activities

–OR–

Peak Flow: _____ to _____
(50 to 79 percent of my best peak flow)

1 **Add quick-relief medicine — and keep taking your GREEN ZONE medicine.**

_____ (short acting B_2 agonist)

☐ 2 or ☐ 4 puffs every 20 minutes for up to 1 hour

☐ Nebulizer, once

If applicable remove yourself from the thing that made your asthma worse

2 **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

☐ Continue monitoring to be sure you stay in the green zone

–OR –

If your symptoms (and peak flow, if used) do NOT return to GREEN ZONE after 1 hour of above treatment:

☐ Take _____ (short acting B_2 agonist) ☐ 2 or ☐ 4 puffs or ☐ Nebulizer

☐ Add _____ (oral corticosteroid) mg per day. For _____ (3-10) days

☐ Call the doctor _____ (phone) ☐ before ☐ within _____ hours after taking the oral corticosteroid

RED ZONE

MEDICAL ALERT

- Very short of breath, or
- Quick relief medicines have not helped, or
- Cannot do usual activies, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

–OR–

Peak Flow: less than _____
(50 percent of my best peak flow)

Take this medication:

☐ _____ (short acting B_2 agonist) ☐ 4 or ☐ 6 puffs or ☐ Nebulizer

☐ _____ (oral corticosteroid)) mg.

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the RED ZONE after 15 minutes AND
- You have not reached your doctor

Danger Signs

- **Trouble walking and talking due to shortness of breath**
- **Lips or figernails are blue**

- **Take ☐ 4 or ☐ 6 puffs of your quick-relief medication AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW**

Source: National Heart,Lung, and Blood Institute. National Institutes of Health, U.S. Department of Health and Human Services. NIH Publication No 07-5251, October 2006.
Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:119.

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

	Today's Date
Child's Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Primary Health Care Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

Other: _____

Additional comments: _____

_____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*

Instructions for Completing the
Care Plan for Children with Special Health Needs (CH-15)

This Care Plan template is designed to supplement the Universal Child Health Record (UCHR, CH-14). It should be used for children with special health needs (CSHN). The UCHR is designed to be concise and does not provide sufficient space for detailed instructions that a CSHN might need. Use this Care Plan when your instructions for the child's care cannot be fit on to the UCHR. This Care Plan should be utilized as a template that can be adapted as needed. Not all parts need to be completed for some children, but other children may require extra pages to be attached to fully explain the instructions for the child's care.

In order to facilitate communication between the health care provider and the parent, it may be best to complete this form with the parent/guardian present. Parents often have practical knowledge that is important to incorporate into the plan, such as techniques to get the child to cooperate with treatments and specifics about the child care site/school like the hours attended and the resources/limitations of the out-of-home care provider. There is room at the end for optional parent notes and signature that will give permission for communication between the health care provider and the child care provider or school nurse.

Specific Instructions:

1. Complete the Universal Child Health Record (UCHR, CH-14).
2. Attach a copy of immunization record.
3. As appropriate check off the box labeled "Special Care Plan Attached."
4. Complete the Care Plan for Children with Special Health Needs
    - Complete the demographic information.
    - The Primary Health Care Provider is the medical home where the child's complete health records are maintained.
    - Specialty providers and their contact information should be included if the specialists play a major role in the child's health care such as adjusting medication doses.
    - Diagnosis – Include major diagnoses (preferably using lay terminology as necessary).
    - Allergies – Include medication allergies and other significant environmental allergies.
    - Routine Care – Complete the medication information. Include important side effects that child care providers should be watching for both with medications administered at home as well as those given at child care.
    - Describe any Needed Accommodations to particular activities.
        - Describe special diets or feeding techniques which may be needed such as feeding pureed foods, maintaining upright positioning during feeds, following a restrictive diet, etc.
        - Classroom activities – List any modifications needed to allow the child to participate such as extra rest breaks, use of adaptive equipment, etc.
        - Outdoor Activities/Field Trips- List any special precautions needed for class trips such as emergency kits, mobile phones, special vehicles, etc.
    - Special Equipment/ Medical Supplies
        - List special equipment that may be needed such as nebulizers, peak flow meters, glucometers, braces, hearing aids, wheelchairs, apnea monitors, etc.
    - Emergency Care
        - Help the child care providers to understand which signs/symptoms merit calling the parents and which are more serious and indicate that EMS should be activated.
        - Describe interim measures that should be taken while waiting for parent or EMS arrival such as administering an asthma nebulizer treatment or an Epi-Pen.
    - Special Staff Training
        - Are there special trainings that staff should attend in order to care for the child such as medication administration training, first aid/CPR, etc.? Include who might be available to provide such training.

Information Exchange on Children with Health Concerns Form

Dear Health Care Provider:
We are sending you this Information Exchange Form along with a Consent for Release of Information Form (see back) because we have a concern about the following signs and symptoms that we and/or the parents have noted in this child, who is in our care. We appreciate any information you can share with us on this child in order to help us care for him/her more appropriately, and to assist us to work more effectively with the child and family. Thank you!

To be filled out by Child Care Provider:

Facility Name: _____ Telephone: _____

Address: _____

We would like you to evaluate and give us information on the following signs and symptoms: _____

_____

_____

_____

Questions we have regarding these signs and symptoms are: _____

_____

_____

_____

Date__ _/___ /___ Child Care Provider Signature: _____

Child Care Provider Printed Name: _____

To be filled out by Health Care Provider:

Health Care Provider's Name: _____ Telephone: _____

Address: _____

Diagnosis for this child: _____

Recommended Treatment: _____

_____

_____

_____

Major side effects of any medication prescribed that we should be aware of: _____

_____

Should the child be temporarily excluded from care, and if so, for how long? _____

_____

What should we be aware of in caring for this child at our facility (special diet, treatment, education for parents to reinforce your instructions, signs and symptoms to watch for, etc.)?

_____

_____

_____

Please attach additional pages for any other information, if necessary.

Date__ _/___ /___ Health Care Provider Signature: _____

Health Care Provider Printed Name: _____

Consent for Release of Information Form

I, _____, give my permission for
(parent/guardian)

_____to exchange health information with
(sending professional/agency)

_____.
(receiving professional/agency)

This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time. This information will be used to plan and coordinate the care of:

Name of Child: _____ Date of Birth: _____

Parent/Guardian Name: _____
(print full name)

Parent/Guardian Signature: _____

Parents or Guardians signing this document have a legal right to receive a copy of this authorization.

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable California laws, all personal and health information is private and must be protected.

Adapted from : Pennsylvania Chapter of the American Academy of Pediatrics (1993). Model Child Care Health Policies. Bryn Mawr: PA: Authors.

Daily Log of Controlled Medications Administered

Use one Sheet for Each Child

School/Childcare Program_____

Child's Name _____Birth Date _____Classroom_____
Medication_____Dosage_____Route_____
Time of day medication is to be given_____
Length of time medication is to be given:_____ Start Date _____End Date_____
Special Instructions_____
Name of Health Care Provider Prescribing Medication _____Phone_____

***All medication received must be counted and signed by staff member as well as guardian**.

Date	# of Pills Received Date & Initial (Staff & Guardian)	Time of administration	# of Pills Remaining	Initials	Comments

Staff Signature	Initials	Date

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

_____ ____/____/____
Name of Facility/School Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

_____
Prescribing Health Professional's Name

_____
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Address

_____
Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

Safety Check

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

_____

Caregiver/Teacher Name (Print)

_____

Caregiver/Teacher Signature

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

_____

_____

_____

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature _____

Adapted with permission from Healthy Child Care Colorado.

Washing Your Hands

1. Turn water on.

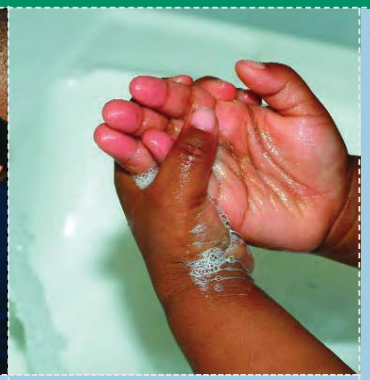
- Be sure **clean, disposable paper towels** are available.
- Turn on **warm water.** (90-110°F in NC)

2. Wet hands.

- Wet hands with water.

3. Apply soap.

- Apply **liquid soap.**



4. Wash hands.

- Wash hands well for at least 10-15 seconds. Rub top and inside of hands, under nails and between fingers.

5. Rinse hands.

- Rinse hands under running water for at least 10 seconds.

6. Dry hands.

- Dry hands with clean, disposable paper towel.

7. Turn water off.

- Turn off the water using the paper towel.

8. Throw paper towel away.

- Throw the paper towel into a lined trash container.

Teach children to wash their hands:

- Upon arrival to the center

- Before and after eating

- After using the toilet/diapering

- After coughing or contact with body fluids: runny nose, blood, vomit
- Before and after using water tables
- After outside play
- After handling pets

- Whenever hands are visibly dirty
- Before going home

North Carolina Child Care Health & Safety Resources Center • 1.800.367.2229 • www.healthychildcarenc.org • The development, translation, and mailing of the Washing Your Hands Poster are supported by funding from the Child Care and Development Fund Block Grant of the Child Care Bureau, Administration on Children and Families, USDHHS, through a contract between the NC Division of Child Development, NCDHHS, and the Department of Maternal and Child Health, School of Public Health, The University of North Carolina at Chapel Hill.

HANDWASHING

Handwashing is the single most effective practice that prevents the spread of germs in the child care setting.

When should hands be washed?

Children:

- ☐ Upon arrival to the center
- ☐ Before and after eating
- ☐ After using the toilet/diapering
- ☐ Before using water tables
- ☐ After playing on the playground
- ☐ After handling pets
- ☐ After coughing or contact with runny noses
- ☐ Whenever hands are visibly dirty
- ☐ Before going home

Providers

- ☐ Upon arrival to work
- ☐ Before handling food or feeding children
- ☐ After using toilet/diaper changing
- ☐ After coughing, contact with runny noses, vomit, etc
- ☐ After handling pets or pet cages
- ☐ Whenever hands are visibly dirty
- ☐ Before and after administering first aid
- ☐ After cleaning up
- ☐ After removing gloves
- ☐ Before and after giving medication
- ☐ Before going home

How to wash hands

- ✓ Refer to the Handwashing handout
- ✓ Use liquid soap
- ✓ Wash well under running water for at least 10-15 seconds.
- ✓ Be sure to wash areas between fingers, around nail beds, under fingernails and back of hands
- ✓ Use hand lotion

Hand sanitizers may be used for staff and children 3 years of age and older, at times and in areas where handwashing facilities are not available

Infants and Toddlers

Use soap and water at a sink if you can. If a baby is too heavy to hold for handwashing at the sink then:

- ☐ Wipe the child's hands with a damp paper towel moistened with a drop of liquid soap.
- ☐ Wipe the child's hands with a paper towel wet with clear water
- ☐ Dry the child's hands with a paper towel
- ☐ Do not use hand sanitizers for young children under 3 years of age

Dear Parent/Guardian:

With the safety of your child in mind, we would like to make you aware that we have developed a Medication Administration Policy for our child care facility. This detailed policy is comprehensive and involves the ideas of child care providers and directors in accordance with legal regulations.

If you need us to give medicine to your child please remember that we need:

1. Updated emergency contact forms
2. Permission form for EVERY medicine that includes
    a. Name of child
    b. Name of medication
    c. Time the medication should be given and how often
    d. How to give the medicine
    e. How much medicine to give
3. Medicine in the original container and not close to expiration date

We will not give medicine that is:

1. Expired
2. Not in original container
3. Without written permission
4. Beyond the expiration of parent/guardian consent
5. Without written instructions from a physician or other health professional for prescription medicine
6. In a manner that does not match the medicine container or prescription
7. For non-medical reasons (such as giving Benadryl to help a child sleep)
8. Not prescribed for that child

Medicine will be stored in a locked container that is inaccessible to children and stored at the proper temperature. Any medication left 72 hours after authorization or completion of treatment will be returned to you or discarded.

Any medicine we give to your child will be recorded on a Medication Administration log or record which will show the child's name, date, time, amount and type of medication given, as well as the name of the signature of the person who gave medicine. Spills, reactions and refusals will be noted on this document.

If your child has a reaction to any medication, we will contact you immediately and give your child medical attention as needed. We will also contact you if your child refuses the medication.

Please give the first dose of medicine to your child so that you can tell us the best way to give medicine to your child and to avoid problems or allergic reactions.

Dear Parents/ Guardians:

Many parents and staff members have questions regarding the use of medications. The following is some information from local and national pediatric experts about the use of medication in young children.

People in the United States spend millions of dollars on the use of over-the-counter (OTC) medications, (for fever, pain, colds, and coughs). Many of these medications are unnecessary, and in the case of young children (particularly under the age of 5 years) the effect of these medications often produces side effects, instead of providing relief to bothersome symptoms.

In January 2008, the American Academy of Pediatrics (AAP) supported a public health advisory put out by the US Food And Drug Administration. This advisory recommended that OTC cough and cold medications should not be used for infants and children under age 2 because of the risk of life threatening side effects.

It is recommended that parents discuss the use of OTC medications with their health care provider before giving any medications to their child. Parents should be especially careful in giving OTC medications to an infant. Giving a child more than one cold or cough medicine to treat different symptoms can be dangerous. Some of the same ingredients may be in each product. Also, many of these medicines contain acetaminophen. Read labels carefully.

Use of Nonprescription Medications for Common Symptoms:

- If your child is playing and sleeping normally, nonprescription medications are not needed.
- Medications should only be given for symptoms that cause significant discomfort, such as repeated coughing or difficulty with sleeping. Consult with your health care provider.
- Viral illnesses respond well to rest, fluids and comfort measures.

Use of Antibiotics:

- More than 90% of infections are due to viruses.
- Antibiotics have no effect on viruses.
- Antibiotics kill bacteria (such as strep throat). It is essential to complete the full treatment, even though your child may feel well.
- When antibiotics are necessary, they should be given at home when possible; this has been made easier now that once and twice daily dosages are available

If Your Child Requires Medication While at Child Care or School:

- All prescription and nonprescription medication given in child care or school settings require a written authorization from your health care provider, as well as parent written consent. This is a child care licensing requirement. The medication authorization forms are available from the center or school.

- The instructions from your health care provider must include information regarding the medication, reason for the medication, the specific time of administration and the length of time the medication needs to be given. All medication must be brought in the original labeled container.
  Note: Medication prepared in a bottle or "cup" may not be left with program staff. Vitamins are considered like any other medication, please do not leave them with your child.

- Program staff involved in medication administration receives special training and is supervised by a nurse or other health care consultant.

- Program staff is not authorized to determine when an "as needed" medication is to be given. Specific instructions are necessary. For children with chronic health conditions, this can be determined in collaboration with the consulting registered nurse.

Page 2
Medication Use in Young Children

Guidelines for Safe Use of Medication:

- Keep medication out of the reach of children. Keep childproof caps on the container.
- Children should understand **adults are in charge of medicines**.
  It should not be referred to as "candy"
- Give the correct dose. Measure the dose out exactly.
  Use a measuring spoon, medicine spoon or syringe. One teaspoon = 5ml (cc).
  Kitchen teaspoons & tablespoons are **not** accurate; they hold 2-7ml (cc) and should not be used.
- Give the medicine at the prescribed times. If you forget a dose, give it as soon as possible and give the next dose at the correct time interval following the late dose.
- Give medications that treat symptoms (such as: persistent cough) only if your child needs it and never to children under 2. Continuous use is usually not necessary. Talk with your health care provider.
- Young children pay attention to adults who take medication. Sometimes a 2-year-old will tell you they have a headache or stomachache, this is not a reason to use medication. Watch the symptoms and give your child attention in other ways.
- Fever reducing medication can be given for fever over 102°. Remember that fever can be the body's way to fight infection. Be careful not to casually use fever-reducing medication.
- Be especially careful with over-the-counter medications. Some adult strength medications are never used with children. Talk with your health care provider or pharmacist.
- Check the medication label and read the expiration dates. Expired medications can lose their strength and can be harmful.

What to do if Your Child Refuses to Take Their Medicine

- Some medications do not taste very good. Your child can suck on a popsicle beforehand to help numb the taste. Or you can offer your child's favorite drink to help wash it down.
- If the medication is not essential (such as most nonprescription medication) then discontinue it. If you are not sure, call your health care provider.
- If the medication is essential, be firm, help them take it and give a reason for the need.

Should your child need to take medication, either at home at school or at child care, be sure to talk with the program director. When your child is well enough to return to school/childcare, the staff may be able to assist you in monitoring your child during this time, be able to share information about your child's symptoms and how they may be responding to the medication and other comfort measures.

References:
Your Child's Health, 3rd edition, Dr. Barton Schmitt, Bantam Books, 2002.
Healthy Child Care America*: Controlling the Spread of Infectious Disease in Child Care Programs*, 2001
Managing Infectious Diseases in Child Care and Schools, Susan Aronson, Timothy Shope, AAP, 2005
http://www.aap.org/advocacy/releases/jan08coughandcold.htm

Handout developed by The Children's Hospital School Health Program 2001 revised 2005, 2008 (303) 281-2790

CHILD CARE LAW CENTER
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Questions and Answers: IDEA & Child Care

1. What is the IDEA?

The Individuals with Disabilities Education Act (IDEA) guarantees children with disabilities the same access to education as children who do not have disabilities.[1] In 1975, Congress passed the IDEA in response to frequent discrimination against children with disabilities in public school systems. All states must meet the minimum *federal* IDEA standards regarding the educational rights of children with disabilities. However, *state* laws can expand these rights.

2. Who is eligible for services under the IDEA?

Children ages 0 to 21 with certain disabilities are eligible.

- *Infants and Toddlers* – are eligible for Early Intervention (EI) services under the IDEA. EI services may be necessary if a child is experiencing developmental delays or has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.[2] Some states have created a third eligibility category of children at-risk of developmental delays.[3]
- *School-age and Children Attending Preschool* – are eligible if found to have mental retardation, hearing impairments, speech or language impairments, visual impairments, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities, which as a result need special education and related services.[4]

3. How do families apply?

If a parent feels her child is eligible for services under the IDEA, she should contact her local school district or EI agency. Local educational agencies (LEA) have an obligation under federal law to "actively and systematically seek out" all persons aged 3 to 21 who would be eligible for special education.[5] The lead agency for EI services has a similar "child find" obligation for infants and toddlers.[6] Child care providers can refer children they think may be eligible, although the family must consent in writing to an assessment.

4. What is an IEP?

- An Individualized Educational Program (IEP) is an agreement that outlines a child's special education and related services.[7] An IEP is for preschool (ages 3 to 5) and school-age children.
- A team consisting of parents,[8] regular and special education teachers, a representative from the LEA, and anyone else the parent or local school district feel should be present, formulate the IEP at a collaborative meeting.[9]
- The IEP must include the child's present levels of performance, measurable annual goals, and the child's special education and related services.[10] If a child does not participate in the regular classroom or in general nonacademic and extracurricular activities, the IEP must explain why and list supports and program modifications to allow participation in the general classroom.[11] A parent must provide written consent to the services to be provided.[12]
- The team reviews the IEP at least annually, or when either a parent or a teacher request a meeting for a new assessment, lack of anticipated progress by the child, or other matters.[13]

5. What is an IFSP?

- An Individualized Family Service Program (IFSP) is very similar to an IEP, but an IFSP is for EI children, ages 0 to 3.
- An IFSP may include the infant/toddler's present levels of development, the major expected outcomes for the infant/toddler and her family, the specific EI services necessary to meet the needs of the infant/toddler and her family, the natural environments in which the services will be carried out, and steps to help the infant/toddler transition to preschool or other services.[14] A parent must provide written consent to the services to be provided.[15]
- An IFSP is evaluated annually and is reviewed at least every 6 months or more frequently if the infant/toddler or family needs it.[16]

6. What role can child care providers play in the IEP/IFSP process?

At the discretion of the parent or agency, other individuals with "knowledge or special expertise regarding the child,"[17] (IEP) or "as appropriate, persons who will be providing services to the child or family"[18] (IFSP) may participate in the IEP or IFSP meeting and planning. This could include child care providers. Child care providers can give input on services or technology that would enable the child to participate in their program.

7. What placement can families and children obtain under the IDEA?

- The IDEA is designed to guarantee children with disabilities of all ages the opportunity to participate, learn, interact, and succeed in the school setting.
- Children with disabilities in school are assured a *Free Appropriate Public Education* (FAPE). FAPE is not tied to funding and must be based on the child's educational need.[19] Placement is based on the child's individual needs and skills as outlined on her IEP.[20]
- Inclusion is an important goal of the IDEA. Also, for *preschool* and *school-age children* with disabilities, the IDEA requires that they be placed in the *Least Restrictive Environment* (LRE).[21] LRE applies to extracurricular and nonacademic activities as well,[22] which can include child care.
- *EI (ages 0 to 3)* has a "*Natural Environment*" requirement similar to the LRE.[23] A "natural environment" includes a child's home, "community settings in which children without disabilities participate,"[24] and "settings that are natural or normal for the child's age peers who have no disabilities,"[25] such as child care.

8. What related services can families and children obtain under the IDEA?

Families and children can receive any service that is necessary to help a child benefit from her special education program.[26] All services under the IDEA for children ages 3 to 21 are free[27] and based on each child's educational need, not the child's disability. [28] Some examples of these services are transportation, speech pathology, psychological services, physical and occupational therapy, counseling services, and school health services. For children receiving EI services, some states charge fees based on a sliding scale and/or require access to public/private insurance.[29]

9. Can a family get child care or afterschool care through their IEP?

- Children with disabilities, *from ages 3 to 5*, may receive preschool or child care services as part of their IEP. It is also possible to include consultation services between the therapists working with a child and the child's preschool or child care programs in an IEP. The IDEA makes grants available to states to extend special education services to eligible preschool aged children.[30] Some school districts may try to limit reimbursement for placement in private preschools, but this is not allowed if the placement results from the IEP.[31]
- If afterschool care or extended day is a related service that is necessary for a *school-age child* to benefit from her special education, then a family could receive afterschool care through an IEP.[32] The related service must be connected to the child's education and needs, not family or

other issues, *except* in the case of EI where a family's needs and strengths as well as the child's are expressly considered.[33]

- A portion of the cost of child care may be paid for as part of an IFSP.[35] For example, where a child has socialization with typically developing children as a goal in his/her IFSP, the state agency can pay for the time in child care when the child is receiving this support.

10. What assistive technology is available to child care providers for children with disabilities under the IDEA?

- Assistive technology means any equipment, off-the-shelf or customized, used to increase, maintain, or improve the functional capacities of children with disabilities.[36] Some examples of assistive technology are computers, transportation aids, glasses, and hearing aids.

- If assistive technology helps a student benefit from her special education placement, including child care, then the technology is guaranteed by the school district.[37] Parents do not have to pay for the equipment.[38]
- The need for assistive technology must be considered in every child's IEP,[39] and it is an EI[40] service that must be considered in the IFSP process. If the IEP team decides that the child needs access to those devices in non-school settings, such as child care, in order to achieve FAPE, the LEA must allow the child to use a school-purchased assistive technology device at home or in other settings.[41]

11. What rights do parents have if the school district denies a child services or a parent does not like her child's placement?

Parents or the child's representative have the right to mediation and/or a due process hearing if they disagree with their child's IEP or on any matter relating to the child's evaluation, placement, and services under the IDEA.[42] See the resource box for agencies you can contact about more information or assistance.

Useful Resources

- **Call the Child Care Law Center** at **(415) 394-7144** if you would like information about child care issues. We are a national and California child care support center for legal services programs. The following are some of our legal services:
  - Answer legal questions regarding child care on Monday and Thursday from 12p.m. to 3p.m.
  - Write many useful legal and policy publications. Visit our website at www.childcarelaw.org.
  - Conduct trainings for parents, teachers, community agencies, and others on the Americans with Disabilities Act and other disability laws.
- **Call the National Disability Rights Network**, a national voluntary membership organization for the federally mandated nationwide network of disability rights agencies, protection and advocacy systems, and client assistance programs, at **(202) 408-9514** or visit their website at www.napas.org to find out where the office is nearest you.
- **Contact the Parent Training and Information Centers and Community Groups**, which provide training and information to parents of infants, toddlers, school-aged children, and young adults with disabilities, and the professionals who work with their families in your state. To reach the parent center in your state, call the **Technical Assistance Alliance for Parent Centers (the Alliance)** at **(888) 248-0822** or visit their website at www.taalliance.org.
- **Call Disability Rights Education & Defense Fund (DREDF)**, a national law and policy center dedicated to protecting and advancing the civil rights of people with disabilities, at **(510)644-2555** or visit their website at www.dredf.org.
- **Contact Easter Seals Disability Services,** a national non-profit that provides both resources and inclusive child care services. A list of centers and services can be found at their website: http://www.easterseals.com.

This document is intended to provide general information about the topic covered. It is believed to be current and accurate as of June 2009, but the law changes often. This document is made available with the understanding that it does not render legal or other professional advice. If you need legal advice, you should seek the services of a competent attorney.

Endnotes

[1] 20 U.S.C. § 1400 et. seq.
[2] 20 U.S.C. § 1432(5).
[3] 20 U.S.C. § 1432(5)(B).
[4] 20 U.S.C. § 1401(3); see also 34 C.F.R. § 300.7(a)(1) (further specifying eligibility criteria for special education including multiply handicapped).
[5] 20 U.S.C. § 1412(a)(3).
[6] 20 U.S.C. § 1435(a)(5).
[7] 20 U.S.C. § 1414(d) (IEP); 20 U.S.C. § 1436 (IFSP).
[8] Agencies must take extra steps to include parents if they cannot attend, such as enabling them to participate via conference call. 34 C.F.R. § 300.345.
[9] 20 U.S.C. § 1414(d)(1)(B).
[10] 20 U.S.C. § 1414(d)(A).
[11] 20 U.S.C. § 1414(d)(1)(A)(iv).
[12] 20 U.S.C. § 1436(e).
[13] 20 U.S.C. § 1414(d)(4).
[14] 20 U.S.C. § 1436(d).
[15] 20 U.S.C. § 1436(e)
[16] 20 U.S.C. § 1436(b).
[17] 20 U.S.C. § 1414(d)(B).
[18] 34 C.F.R. § 303.343(a)(1).
[19] 20 U.S.C. § 1412(a)(1); 34 C.F.R. § 300.103.
[20] 20 U.S.C. § 1414(d)(3)(A).
[21] 20 U.S.C. § 1412(a)(5).
[22] 20 U.S.C. § 1414(d)(1)(A)(iii).
[23] 20 U.S.C. § 1432(4)(G).
[24] Id.
[25] 34 C.F.R. § 303.18.
[26] 20 U.S.C. § 1414(d)(1).
[27] 20 U.S.C. § 1401(9).
[28] 20 U.S.C. § 1412(a)(1); 34 C.F.R. § 300.103.
[29] INSERT CITE
[30] 20 U.S.C. § 1419.
[31] Id. § 1412(a)(10)(B); see also 34 C.F.R. § 300, App. B.
[32] 20 U.S.C. § 1401(26).
[33] 20 U.S.C. §§ 1436(a).
[35] 20 U.S.C. § 1436(d).
[36] 20 U.S.C. § 1401(1).
[37] 20 U.S.C. § 1412(a)(12)(B)(i).
[38] Id.
[39] 20 U.S.C. § 1414(d)(3)(B)(v).
[40] 34 C.F.R. § 303.12(d)(1).
[41] 34 C.F.R. § 300.105(b).
[42] 20 U.S.C. § 1415(b).

This publication, *Questions and Answers: IDEA and Child Care*, is reprinted with permission from Child Care Law Center. More information about CCLC is available at www.childcarelaw.org.

When Should Students With Asthma or Allergies Carry and Self Administer Emergency Medications at School?

Guidance for Health Care Providers Who Prescribe Emergency Medications

Physicians and others authorized to prescribe medications, working together with parents and school nurses, should consider the list of factors below in determining when to entrust and encourage a student with diagnosed asthma and/or anaphylaxis to carry and self-administer prescribed emergency medications at school.

Most students can better manage their asthma or allergies and can more safely respond to symptoms if they carry and self-administer their life saving medications at school. **Each student should have a personal asthma/allergy management plan on file at school that addresses carrying and self-administering emergency medications**. If carrying medications is not initially deemed appropriate for a student, then his/her asthma/allergy management plan should include action steps for developing the necessary skills or behaviors that would lead to this goal. All schools need to abide by state laws and policies related to permitting students to carry and self-administer asthma inhalers and epinephrine auto-injectors.

Health care providers should assess student, family, school, and community factors in determining when a student should carry and self-administer life saving medications. **Health care providers should communicate their recommendation to the parent/guardian and the school**, and maintain communication with the school, especially the school nurse. Assessment of the factors below should help to establish a profile that guides the decision; however, responses will not generate a "score" that clearly differentiates students who would be successful.

Student factors:

- Desire to carry and self-administer
- Appropriate age, maturity, or developmental level
- Ability to identify signs and symptoms of asthma and/or anaphylaxis
- Knowledge of proper medication use in response to signs/symptoms
- Ability to use correct technique in administering medication
- Knowledge about medication side effects and what to report
- Willingness to comply with school's rules about use of medicine at school, for example:
  - Keeping one's bronchodilator inhaler and/or auto-injectable epinephrine with him/her at all times;
  - Notifying a responsible adult (e.g., teacher, nurse, coach, playground assistant) during the day when a bronchodilator inhaler is used and *immediately* when auto-injectable epinephrine is used;
  - Not sharing medication with other students or leaving it unattended;
  - Not using bronchodilator inhaler or auto-injectable epinephrine for any other use than what is intended;
- Responsible carrying and self-administering medicine at school in the past (e.g. while attending a previous school or during an after-school program).

NOTE: Although past asthma history is not a sure predictor of future asthma episodes, those children with a history of asthma symptoms and episodes might benefit the most from carrying and self-administering emergency medications at school. It may be useful to consider the following.

- Frequency and location of past sudden onsets
- Presence of triggers at school
- Frequency of past hospitalizations or emergency department visits due to asthma

EpiPen® Resources

Parent Brochures

- Anaphylaxis
  www.aap.org/publiced/BR_Anaphylaxis.htm

Reports and Position Statements

- "School Guidelines for Managing Students with Food Allergies" — Several organizations have developed thoughtful summaries of shared responsibilities concerning food allergies for use by schools, children, adolescents, and parents (a list is available online at www.foodallergy.org/school/SchoolGuidelines.pdf).
- AAAAI Board of Directors. American Academy of Allergy, Asthma and Immunology. Anaphylaxis in schools and other childcare settings. *J Allergy Clin Immunol*. 1998;102:173–176
  www.aaaai.org/members/academy_statements/position_statements/ps34.asp

Pediatrics

To access the articles below, please visit www.healthychildcare.org/medadmin.html:

- Davis, KL, Mikita, CP. Parental Use of EpiPen for Children with Food Allergies. *Pediatrics*. 2006:118:S18-S19
- Forman, JA, Noone, SA, Sicherer, SH. Use Assessment of Self-Administered Epinephrine Among Food-Allergic Children and Pediatricians. *Pediatrics*. 2000:105;359-362
- Banks, JR. EpiPen Jr Versus EpiPen in Young Children Weighing 15 to 30 kg at Risk for Anaphylaxis. *Pediatrics*. 2003; 112;460-461

Pediatric Care Online

- Epinephrine (see navigation menu on left to get info on usage, dosing, etc)
  www.pediatriccareonline.org/pco/ub/view/Pediatric-Drug-Lookup/153609/all/epinephrine

Candy or Medicine? — Look Alike Drugs

Because young children are unable to read they can often mistake medicines for their favorite candy. The reason is pictured above; many medicines and candies look virtually identical. To reduce the risk of accidental poisonings, keep medicines out of reach of children in a high, locked cabinet; and always keep medicines in the original container. In the event of an accidental poisoning:

CALL POISON CENTER IMMEDIATELY 1-800-222-1222

Look Alike Products — Don't Be Fooled

Candy & medicine can look alike!

A child's view … it all looks like candy!

Carolinas Poison Center June

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Medication Administration in Early Education and Child Care Settings

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