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

Name of Facility/School: ABC Child Care Center
Today's Date: X / X / 20XX

Name of Child (First and Last): Nick Sample
Date of Birth: Y / Y / 0Y

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: O / O / 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

Prescribing Health Professional's Name: Elaine Donoghue, MD

Phone Number: (732) 775-5500

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): Nicole Sample

Parent or Guardian Signature: Nicole Sample

Address: 123 Main Street, Anywhere USA

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

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 / 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
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

Condition		Comments
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 Occasional ear infections
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	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 /20xy
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

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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

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