Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____Date_____ I,

_____**, (parent or guardian) gives permission**

(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
***** For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:

__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)
__ Other: _____

Plan is maintained by:

__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (please print):_____

Licensed Health Care Practitioner authorization:_____Date: _____

Parental/Guardian consent: _____ Date: _____

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/Health Care Provider _____ Phone numbers _____

■ Physician Signature _____ Date _____

Severity Classification

❍ Mild Intermittent ❍ Moderate Persistent
❍ Mild Persistent ❍ Severe Persistent

Triggers

❍ Colds ❍ Smoke ❍ Weather
❍ Exercise ❍ Dust ❍ Air pollution
❍ Animals ❍ Food
❍ Other _____

Exercise

1. Pre-medication (how much and when) _____
_____
2. Exercise modifications _____
_____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or
_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

❍ Take quick-relief medication every 4 hours for 1 to 2 days

❍ Change your long-term control medicines by
_____

❍ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

❍ Take quick-relief treatment again

❍ Change your long-term control medicines by
_____

❍ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or
_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

❍ Still in the red zone after 15 minutes

❍ If you have not been able to reach your physician/health care provider for help

❍ _____

Call an ambulance immediately if the following danger signs are present

❍ Trouble walking/talking due to shortness of breath

❍ Lips or fingernails are blue