

Consent to Administer Medication and/or Treatment Plan in a Department of Human Services Program

In order for a medication plan (prescription and non-prescription), and/or treatment plan to be given to your child during a Department of Human Services Program (DHSP), this form needs to be completed by both you and your child's doctor or clinic. (Please note: nurses are not on staff at our programs.) Return the completed form to your child's program staff. Printed attachments from your health care provider can be attached to this form. An original signature form your health care provider is required below.

Name of Child _____ Date of Birth _____ Program _____

MEDICAL PROVIDER INFORMATION

Diagnosis* _____ Symptoms _____

Any other medical condition(s)*/Allergies _____

Medication Plan

Medication _____ Route of Administration _____

Dosage _____ Frequency _____

Time(s) of Administration _____ Date of Order _____ End date _____

Specific directions or information for medication plan _____

Other medication Information: (side effects, contraindications, or possible adverse reactions; other medications being taken, specific directions for storage) _____

Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate) Yes No

Treatment Plan/Care Plan

Description of chronic health condition _____

Special healthcare and/or treatments necessary while child is in program _____

Potential side effects of treatment and consequences if the treatment isn't administered _____

Adaptation to specific activities on-site and/or off-site _____

 _____ Signature of Licensed Prescriber	_____ Please Print Name Here	_____ Business Telephone Number
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PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name _____

Parent/Guardian Name _____

Tel # (H) _____

Tel # (H) _____

(W) _____

(W) _____

Other person(s) to be notified in case of medication emergency:

Name: _____

Telephone number: _____

Name: _____

Telephone number: _____

I give permission to have the program staff administer this medication and/or treatment/care plan	___ Yes ___ No (Please Initial)
I give permission to the program staff to share information relevant to the prescribed medication and/or treatment/care plan as s/he determines appropriate for my child's health and safety.	___ Yes ___ No (Please Initial)
I give permission to the program staff to photograph my child, to keep on file for identification purposes only and/or to provide the program with my child's picture if needed.	___ Yes ___ No (Please Initial)
I understand I may retrieve the medication from the program at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order.	___ Yes ___ No (Please Initial)
I give permission for the topical application of sunscreen/insect repellent and/or vaseline by staff.	___ Yes ___ No (Please Initial)
I understand the 1 st dose of any medication must be given by the Parent/Guardian unless it's an epi-pen.	___ Yes ___ No (Please Initial)

 _____ Parent/Guardian Signature	_____ Date
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*If not in violation of confidentiality