

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 **not** 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? <div style="display: flex; justify-content: space-between;"> YES (indicate changes below) NO (updated physician/parental signatures required) </div>	
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: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____