Banner Christian School

rev. 4-24-14
P.O. Box 74010
North Chesterfield, Virginia 23236
Phone: 804-276-5200
Fax: 804-276-7620
www.bannerchristian.org

BCS Student Picture

10 DAYS or LESS - WRITTEN MEDICATION CONSENT FORM

- This form MUST be complete in a language in which the MAT personnel can understand. No medical abbreviations or shorthand.
- One form MUST be completed for each MEDICATION. ***Multiple medications cannot be listed on one consent form.***
- The child's health care provider MUST complete #1 through #18 for medications to be administered 11+ days or when dosage directions state "consult a physician". The parents/legal guardian completes #19 to #23.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen or insect repellent.

1. Child's first and last name:	2. Date of Birth	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route: __ oral __ inhaled __ topical __patch __ eye __ ear __ Nebulizer __ Other:_____

7a. Frequency to be administered:_____

OR

7b. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, have measurable paramenters)_____
_____
_____

8a. Possible side effects: ___ See package insert or pharmacy printout for complete list of possible side effects.

8b. Additional side effects:_____

9. What action should the MAT personnel take if side effects are noted?

__ Contact parent (phone #_____) __ Contact Health Care Provider (phone # _____)

__ Contact 911 ___
Other:_____

10a. Special instructions: __Parents will supply package insert or pharmacy printout for complete list of special instructions

AND/OR

10b. Additional special instructions: (include any concerns related to possible interactions with other medications the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies, or any pre-existing conditions. Also describe situations when medication should NOT be administered.)
_____
___
_____
___

11. Reason the child is taking this medication (unless confidential by law):_____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more, and requires health and related services of a type or amount beyond that required by children generally: __ no __ yes If you checked YES, you need to complete #33 and #34 on the back of this form.
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time, or frequency the medication is to be administered? __No __Yes If you checked YES, you need to complete #35 and #36 on the back of this form.

14. Date consent form completed:	15. Date 10 days will expire or date to be discontinued if prior to 10 days:
16. Prescriber's Name: (please print)	17. Prescriber's Phone Number:
18. Licensed authorized health care provider's signature: (required for all Nebulizers and EpiPens)	

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PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 TO #23)

19. If Section #7a is completed, do the instructions indicate a specific time to administer the medication? (example: 10:00 am) __ No __ Yes __ N/A If yes, write the specific time(s) the MAT personnel is to administer the medication:_____
20. I, parent/legal guardian, authorize the Banner MAT personnel to administer the medication as specified to my child: _____ Child's full name

21. Parent/legal guardian name: (please print)	22. Parent/legal guardian signature:	23.Date Authorized:

BANNER CHRISTIAN TO COMPLETE THIS SECTION (#24 TO #30)

24. Provider/School Name: **BANNER CHRISTIAN SCHOOL**	25. Facility Phone Number: **804-276-5200**	26. (leave blank)
27. I have verified that #1 to #23 and if applicable, #33 to #36 are complete. My signature indicates that all information needed to give this medication has been given to Banner Christian School.		
28. MAT Personnel: (please print)	29. MAT Personnel Signature:	30. Date received from parent/legal guardian:

#31 AND #32 SHOULD ONLY BE COMPLETED IF THE PARENT REQUEST TO <u>DISCONTINUE</u> THE MEDICATION PRIOR TO THE DATE INDICATED IN SECTION #15

31. I, parent/legal guardian request that the medication indicated in section #4 on this consent form, be discontinued on (date)_____. Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new Written Medication Consent Form MUST be completed in its entirety.
32. Parent/Legal Guardian signature: _____

LICENSED HEALTH CARE PRESCRIBER TO COMPLETE, AS NEEDED (#33 TO #36)

33. Describe any additional training, procedures, or competencies that Banner's MAT personnel will need to care for this child:

_____

_

_____

_

_____

_

34. Licensed Health Care Prescriber's Signature:_____
Date:_____

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

Date:_____

By completing this section, Banner Christian School, will follow the written instructions on this form and **NOT** follow the pharmacy label until the new prescription has been filled.

36. Licensed Health Care Prescriber's Signature:_____
Date:_____