



Banner Christian School

rev. 4-24-14
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BCS
Student
Picture

11 or MORE DAYS - 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: <input type="checkbox"/> oral <input type="checkbox"/> inhaled <input type="checkbox"/> topical <input type="checkbox"/> patch <input type="checkbox"/> eye <input type="checkbox"/> ear <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other: _____
7a. Frequency to be administered: _____ <div style="text-align: center;">OR</div>			
7b. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, have measurable parameters) _____ _____ _____			
8a. Possible side effects: <input type="checkbox"/> 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? <input type="checkbox"/> Contact parent (phone # _____) <input type="checkbox"/> Contact Health Care Provider (phone # _____) <input type="checkbox"/> Contact 911 <input type="checkbox"/> Other: _____			
10a. Special instructions: <input type="checkbox"/> Parents will supply package insert or pharmacy printout for complete list of special instructions <div style="text-align: center;">AND/OR</div>			
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): _____			

<p>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: <input type="checkbox"/> no <input type="checkbox"/> yes If you checked YES, you need to complete #33 and #34 on the back of this form.</p>	
<p>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? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked YES, you need to complete #35 and #36 on the back of this form.</p>	
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)

<p>19. If Section #7a is completed, do the instructions indicate a specific time to administer the medication? (example: 10:00 am) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A If yes, write the specific time(s) the MAT personnel is to administer the medication: _____</p>		
<p>20. I, parent/legal guardian, authorize the Banner MAT personnel to administer the medication as specified to my child: _____ Child's full name</p>		
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)
<p>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.</p>		
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 DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN SECTION #15

<p>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.</p>
<p>32. Parent/Legal Guardian signature: _____</p>

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:

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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: _____