BRIGHT HORIZONS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

MEDICATION TYPE:

❐ **PRESCRIPTION** ❐ **NON-PRESCRIPTION** ❐ **TOPICAL OINTMENT**

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Bright Horizons agents to administer the following medication to my child:

Child's Name: ____

- **Prescription Medications:** must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
- **Non-prescription Children's Medication:** can be administered for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent/guardian Written authorization from the child's medical provider is required to continue use beyond the three consecutive days.
- **Non-prescription Topical Children's Ointments:** can be applied with authorization from the parent/guardian according to the manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.
- **Non-prescription Topical Children's Ointments:** can be applied to **open, oozing sores** for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent/guardian. This includes diaper cream, sunscreen, insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children. Written authorization from the child's medical provider is required to continue use beyond the three consecutive days or if the condition worsens.
- **As Needed Children's Medications:** require written authorization from the child's medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.
- **Medications for Chronic Illnesses**: require a written order from the child's medical provider for a period not to exceed ***one year***. (See Prescription and Non-prescription medication above for details)

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Bright Horizons Children's Centers LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Medication: ____

Administration Route: ______________________________________

Reason for Medication: _____________________________________

Medication Storage: _______________________________________

Side Effects: ____

____

Six Rights of Medication

1. **Verification that the *right* child receives**
2. **The *right* medication**
3. **In the *right* dose**
4. **At the *right* time**
5. **By the *right* method**
6. ***And the right* documentation is completed**

Dosage: ____

Times of Administration: _______________ _______________ _______________ _______________

Start Date: ____________________________________ End Date: ______________________________

Physician's Name: ________________________________ Physician's License Number: _______________

Physician's Signature: ___________________________________ Date: ____________________________

Parent/Guardian Signature: ______________________________ Date: ____________________________

Bright Horizons
Asthma Action Plan

Child's Name: ____________________________ Date of Birth: ________________
Facility Name: ____________________________ Date: ________________________

The following information should be completed by the child's medical provider and parent/guardian.

Severity: ☐ Mild ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Check all triggers: (completed by child's medical provider)
☐ Smoke (cigarette) ☐ Colds/flu ☐ Dust mites ☐ Exercise:_______________ __________
☐ Sudden temperature changes ☐ Ozone Alert ☐ Pet dander ☐ Strong Odors______________________
☐ Wood smoke ☐ Cut flowers, grass or pollen ☐ Mold ☐ Food: ________________
☐ Cleaning Products: ____
☐ Others: ____

Suggested classroom strategies to support this child's needs
____
____
____
____

Specific Medical Information:

Medication to be administered: ☐ Yes ☐ No If yes, medication to be administered:_____________________

☐ Authorization for Administration of Medication Form: completed by the Medical Provider and Parent/Guardian on file (Including type of medication, method of administration, time schedule, potential side effects)

Location of medication to be administered:____
Additional medication information: ____
____

Special Staff Training Needs:

Type (be specific): ____
____
____
Training done by: ______________________________ Date of training: ____________________________
Staff trained: ____
____

Additional Emergency Procedures/Instructions:
____
____
____
____

Notify parent/guardian: (name)____Phone #: ________________

Notify parent/guardian: (name)____Phone #: ________________

Emergency Contact: (name) ____ Phone #: ________________

GO (Green Zone)

The child is able to do all of these:	What to do:	Medication:
• Breathing is regular • No cough or wheeze • Can engage in active play	• Allow current activity	• "As needed medication" not needed at this time • Regular medication should be given as ordered

CAUTION (Yellow Zone)

The child has any of the following:	What to do:	Medication
• Early signs of a cold (runny nose, sneezing) • Exposure to a known trigger • Cough • Mild Wheeze • Chest tightness	• Cease current activity • If the child is outdoors bring inside • Observe breathing before and after the treatment (15 minutes)	• Administer the "As needed medication" (see the medication administration form and follow directions for use) • Monitor breathing status if no improvement follow the steps for the DANGER (Red Zone)

DANGER (Red Zone)

The child's asthma is worse and any of the symptoms are seen:	What to do:	Medication:
• The medications are not helping within 15-20 minutes of being given. • Breathing is becoming hard and fast • Nose (nostrils) open wide • Ribs are showing • Lips, fingernails or mouth area are blue or blue gray in color • Trouble walking or talking	• Activate EMS (emergency medical services) • Stay with the child—Stay calm • Ancillary staff notify the parent/guardian • Accompany the child to ER • Complete an incidence form within 24 hours	• Medication available has already been given with no relief • Notify EMS staff regarding the type of medication and the time it was given.

Follow-up: Update/Revision:

This plan may be updated/revised whenever this child's medication(s) or health status should change.

Date of update/revision: ____

Updated plan/revision on file: ☐ Yes ☐ No

This plan has been reviewed/approved by:

Signatures:

Parent/Guardian: ____ Date: ____________________

Medical Provider: ____Date: ____________________

Director/Principal: ____Date: ____________________

(This plan contains information from California Childcare Health Program (CCHP): http://www.ucsfchildcarehealth.org and http://foodallergy.org/)

This plan must be updated annually or whenever the child's medication or health status changes.

Bright Horizons
Health Accommodation Form

Child's Name: _________________________ **Date of Birth:** _________________________
Parent's/Guardian's Name: ____
Physician: ________________________________**Phone:** ____________________________

Diagnosis: ____
____
____

Accommodations while at the Center: ____
____
____

Specific Medical Information

Medication to be administered: □ Yes □ No If yes, medication to be administered including any potential side effects:
____
____
____

□ Authorization for Administration of Medication Form: to be completed by the physician and parent/guardian (including type of medication, method of administration, time schedule, potential side effects)

Additional medication information: ____
____
____
____

Suggested classroom strategies to support this child's needs:
____
____
____
____

Activities: Please specify if the child may/is able to participate in the following daily activities. Note any restrictions or limitations under comments.

Activity	Able to Participate (Yes/No)	Comments/Specific Accommodations
Circle Time (sitting on the floor) (quiet activity)		
Explorative Activities • Dress Up		
• Family Living Kitchen Area		
• Block/Sand/Water areas		
• Discovery table		

Outdoor activities Playground (includes slides, swings and climbing equipment, tricycles)		
Gross Motor Activity		
Walking		
Running/Climbing		
Lifting Objects		

Potential consequences to child if treatment is not administered: ________________________
____
____
____

If applicable, staff will:

- Complete a training specific to (diagnosis)____________________________________
  ____
  ____
- Staff will be able to recognize: ____
  ____
  ____
- Staff will notify the parent/guardian if any of the following conditions exist:
  ____
  ____
  ____

For MA centers only:

Staff may be trained by:
____

The following staff have been trained on the child's medical condition:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

All those who sign this Health Accommodation Form have read the above and are in agreement with the established plan.

____________________________________ ______________________
Parent/Guardian Signature Date

____________________________________ ______________________
Physician Signature Date

____________________________________ ______________________
Director/Principal Signature Date

This plan must be updated annually, whenever there is any change in treatment or the child's condition changes.