Bright Horizons FAMILY SOLUTIONS®

FORM

Medication Authorization Form

MEDICATION TYPE: ❒ **PRESCRIPTION** ❒ **NON-PRESCRIPTION**

Child's Name: _____ **Date of Birth:** _____

All medication must be provided in the original container, labeled with the child's full name. Where applicable, the implement for proper measurement must be provided and labeled with the child's full name. If not provided, medication cannot be administered. Non-prescription medications must be designated for use for children on the label.

I have read the *Medication Administration Policy* in the Bright Horizons Family Guide and I hereby authorize Bright Horizons agents to administer the following medication to my child.

Prescription Medications: must and have a current pharmacist's unaltered label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the medical provider. The instructions from the child's authorized representative shall not conflict with the label directions as prescribed by the child's medical provider.

Non-prescription Medication: with written authorization from parent/guardian can be administered according to the manufacturer's instructions. Written authorization from the child's medical provider is required for any deviation in manufacturer's instructions.

Standing Orders: with written authorization from the child's medical provider may be administered according to physician's instructions for **a period not to exceed six months**. Authorization must list the reason, dosage, instructions, start date and end date.

Medications for Chronic Illnesses: require a health care plan completed by the child's medical provider for a period not to exceed one year. Must include complete medication administration information, otherwise a completed Medication Authorization Form signed by medical provider is required (See Prescription and Non-prescription medication above for details).

Homeopathic/Herbal/Homemade Medications: with written authorization from parent/guardian can be administered according to the manufacturer's instructions. Written authorization from the child's medical provider is required for any deviation in manufacturer's instructions and to administer any homeopathic teething gels or tablets.

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.

On behalf of myself, my family and my minor child, I hereby release and agree to defend, hold harmless, and indemnify Bright Horizons Family Solutions LLC., its subsidiaries, affiliates, and employees, from any and all claims of injury or damage (including personal injury) 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: _____

Dosage: _____

Times of Administration: _____ _____ _____ _____

Start Date: _____ End Date: _____

Side Effects: _____

Parent/Guardian Signature: _____ Date: _____

Physician's Name: _____ Physician's License Number: _____

Physician's Signature: _____ Date: _____

Bright Horizons FAMILY SOLUTIONS®

FORM

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	Treatment/Substitution
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission: ☐ Ingestion ☐ Contact ☐ Inhalation

Note: Do Not Depend on Antihistamines or Inhalers to treat a severe reaction. USE EPINEPHRINE.

Extremely Reactive to the Following Foods_____; therefore:

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**

☐ **If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

For the following signs of a *mild* allergic reaction administer: _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **Nose:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

For any of the following signs of a *severe* allergic reaction or a combination of symptoms from different body areas, give Epinephrine and call 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. *If breathing is difficult or vomiting, place on side, or sit up.*

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart**: Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short of Breath

☐ **Skin:** Many hives over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instructions: _____

_____

Prescribed Medications/Dosage:

Epinephrine (brand and dose)**:** _____

Antihistamine (brand and dose)**:** _____

Other (e.g., inhaler-bronchodilator if asthmatic**):**_____

Potential Side Effects of Medication: _____

_____

Potential Consequences to Child if Treatment is Not Administered: _____

_____

For MA centers only:

Staff may be trained by: _____

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

_____ _____

_____ _____

_____ _____

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Director/Principal Signature Date

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s) ; or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

_____ _____
Parent/Guardian Signature Date

*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Medication Authorization* form.

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