



## FKO Medication Packet

**TO BE COMPLETED FOR ALL MEDICATION TAKEN BY YOUR CHILD,  
REGARDLESS IF MEDICATION WILL BE ADMINISTERED AT FKO.**

Name of Child: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

My child (listed above) takes the following medication:

	Name of Medication	Reason for Medication	Place where Medication is Taken	Time of Day Medication is Taken	Possible Reactions to Medication
1			__ Home __ School __ FKO*		
2			__ Home __ School __ FKO*		
3			__ Home __ School __ FKO*		
4			__ Home __ School __ FKO*		
5			__ Home __ School __ FKO*		

***\*If medication will be administered at FKO, the following policies and procedures MUST be followed:***

- The attached Medicine Administration Form must be signed by you and your child's physician prior to your child's start date.
- If the medication is for a chronic illness/conditions (ADHD, asthma, serious allergies, etc.), the attached Individual Health Care Plan must also be complete prior to your child's start date.
- Your child's medication must be received by the Site Director prior to his/her start date. All medication must be in its original container with the original label.
- If your child's medication expires, you will be responsible to replace with a new prescription in order for your child to continue attending FKO.

If my child requires any medication be administered at FKO, I understand I must follow the above policies and procedures.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**)

### EEC Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at FKO:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Phone Number of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Parental/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FKO Director/Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Older Children ONLY (9+ years of age)**

In accordance with 606 CMR 7.11(3)(b-c) and 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's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FKO Director/Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_