Licensed Child Day Center Program Decision on the Administration of Medication

NOTE: This "sample" *PROGRAM'S DECISION REGARDING MEDICATION* plan meets and in many cases *exceeds* the licensing requirements and/or regulations for child day centers. The "sample" *PROGRAM'S DECISION REGARDING MEDICATION* plan reflects "best practice". Please feel free to adapt and personalize this plan for your child day center

My program has made the following decision regarding the administration of medication: (Check one)

☐ I (or my staff) **WILL NOT** administer prescription medications or non-prescription (over-the-counter) medications. **(Complete Sections 1-4 ONLY)**

☐ I (or my staff) **WILL ONLY** administer non-prescription (over-the-counter) medications. **(Complete Sections 1-4 ONLY)**

☐ I (or my staff) **WILL** administer prescription medication. **(Complete Sections 5-12 ONLY)**

ONLY COMPLETE THIS SECTION IF THE PROGRAM WILL **ONLY** ADMINISTER OVER-THE-COUNTER TOPICAL OINTMENTS, SUNSCREEN AND TOPICALLY APPLIED INSECT REPELLANT

Sections 1-4 *must be completed* ***ONLY*** *if the program plans to administer over-the-counter topical ointments, sunscreen and topically applied insect repellant and* ***not*** *administer any other medication.*

Section 1: Programs That Will NOT Administer Medication OR Will ONLY Administer Over-the-Counter Topical Ointments, Sunscreen and Topically Applied Insect Repellant

I (or my staff) will have parent permission to apply any over-the-counter topical ointment, sunscreen or topically applied insect repellant (TO/S/R) in accordance with VDSS regulations.

Any over-the-counter TO/S/R will be applied in accordance with the package directions for use. If the parent's instructions do not match the package directions, I (or my staff) will get health care provider instructions before apply the TO/S/R.

All over-the-counter TO/S/R will be kept in its original labeled container. All child-specific TO/S/R will be labeled with the child's first and last names.

TO/S/R will be kept in a clean area that is inaccessible to children. Explain where these will be stored.

_____
_____
_____
_____

ONLY COMPLETE THIS SECTION IF THE PROGRAM WILL **ONLY** ADMINISTER OVER-THE-COUNTER TOPICAL OINTMENTS, SUNSCREEN AND TOPICALLY APPLIED INSECT REPELLANT

All leftover or expired TO/S/R will be given back to the child's parent for disposal. TO/S/R not picked up by the parent will be disposed of in a garbage container that is not accessible to children.

All over-the-counter TO/S/R administered to a child during program hours will be documented in the following way:

☐ On a child specific log

☐ Other: _____

All observable side effects will be documented. Parents will be notified of any observed side effects by the end of the day. Parent notification will be immediate if the side effects are severe. If necessary, emergency medical services will be called.

Parents will be notified of all "as needed" over-the-counter TO/S/R applied to their child and told what symptoms were observed that required the application.

The program will: (check one)

☐ Keep a supply of stock over-the-counter TO/S/R to be available for use on children whose parents have given consent. These include the following: (please list)

_____
_____

☐ Only apply over-the-counter TO/S/R which parents supply for their child.

Parent permission will be obtained before any non child-specific over-the-counter TO/S/R will be applied. Parents will be made aware that the TO/S/R being applied is not child-specific and may be used by multiple children.

I (or my staff) will adhere to the following infection control guidelines whenever apply non child-specific TO/S/R:

- Hands will be washed before and after apply the TO/S/R,
- Care will be taken to remove the TO/S/R from the bottle or tube without touching the dispenser,
- An adequate amount of TO/S/R will be obtained so it is not necessary to get more once the provider has stated to apply the TO/S/R (if additional TO/S/R must be dispensed after applying it to a child's skin, hands will be washed before touching the dispenser),
- Gloves will be worn when needed, and
- TO/S/R which may be contaminated will be discarded in a safe manner.

I understand that as a provider it is my obligation to protect the children in my care from injury. Part of this obligation includes the application of sunscreen and/or other topical ointments according to parent permission.

ONLY COMPLETE THIS SECTION IF THE PROGRAM WILL **ONLY** ADMINISTER OVER-THE-COUNTER TOPICAL OINTMENTS, SUNSCREEN AND TOPICALLY APPLIED INSECT REPELLANT

Section 2: Confidentiality Statement

Information about any child in my program is confidential and will not be given to anyone except VDSS' designees or other persons authorized by law unless the child's parent or guardian gives written permission.

Information about any child in my program will be given to the local department of social services if the child received a day care subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

Section 3: ADA Statement

My program will comply with the provision of the Americans with Disabilities Act. If any child enrolled in my program now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the program to meet the needs of the child. If my program can meet the needs of the child without making a fundamental alteration to the program and the child will need regular or emergency medication, I will follow the steps required to have my program approved to administer medication.

Section 4: Provider Statement

I understand that it is my responsibility to follow my *Program's Decision Regarding Medication* plan and all health and infection control regulations applicable to child day programs.

The *Program's Decision Regarding Medication* plan will be made available to parents at enrollment, whenever changes are made and upon request.

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name (please print):	Facility Name:
Provider's Signature:	Date:
Parent or Guardian's Signature:	Date:

Sections 5-12 should be completed ONLY if the program plans to administer medication.

Section 5: For Programs that WILL Administer Medication

The program will administer prescription and non-prescription medication by all routes covered in the MAT course (oral, topical, eye, ear, patches, and inhaled, medications and epinephrine via an auto-injector device).

The program will administer medication in accordance with VDSS child day program regulations pertaining to the administration of medication in a child day program. Only a provider who has completed the appropriate training or has appropriate licensure and is listed as a medication administrator in the *Program's Decision Regarding Medication Plan* will be permitted to administer medication in the program, with the exception of over-the-counter topical ointments, sunscreen and topically applied insect repellant.

Section 6: Authorized Staff to Administer Medication

Section 6 must be completed if the program plans to administer medication.

I understand that any individual listed in this section as a medication administrator is approved to administer medication using the following routes: topical, oral, inhaled, eye, and ear, medication patches and epinephrine using an auto-injector device.

I understand that if a child in my program requires medication rectally, vaginally, by injection or by another route not listed above, I will follow the procedures outlined for children with special health care needs.

I understand that to be approved to administer medication, other than over-the-counter topical ointments, sunscreen and topically applied insect repellent, all individuals listed in my *PROGRAM'S DECISION REGARDING MEDICATION* plan must have valid:

- Medication Administration Training (MAT) certificate
- CPR certificate which covers all ages of the children my program is approved to care for as listed on my registration/license
- First aid certificate which covers all ages of children my program is approved to care for as listed on my registration/license

I understand that the individuals listed in my *PROGRAM'S DECISION REGARDING MEDICATION* plan as medication administrators may only administer medication when the medication labels, inserts, instructions and all related materials are written in the language indicated on the MAT certificate.

Medication Administrator(s)

All staff listed as medication administrators will have first aid and CPR certificates that covers the ages of the children in care and are at least 18 years of age.

ONLY COMPLETE THIS SECTION IF THE PROGRAM **WILL** ADMINISTER MEDICATION

Documentation of age-appropriate first aid and CPR certificates will be kept on site and are available upon request.

(Check one) ☐ **ADD** to list ☐ **CHANGE** information ☐ **REMOVE** from list

Provider Name: ______________________________
MAT certificate expiration date: __________
Signature indicates verification of age, MAT certificate, first aid and CPR certificates: ____________________________ Date: _____________

Additional Staff information (as applicable):

(Check one) ☐ **ADD** to list ☐ **CHANGE** information ☐ **REMOVE** from list

Provider Name: ______________________________
MAT certificate expiration date: __________
Signature indicates verification of age, MAT certificate, first aid and CPR certificates: ____________________________ Date: _____________

(Check one) ☐ **ADD** to list ☐ **CHANGE** information ☐ **REMOVE** from list

Provider Name: ______________________________
MAT certificate expiration date: __________
Signature indicates verification of age, MAT certificate, first aid and CPR certificates: ____________________________ Date: _____________

(Check one) ☐ **ADD** to list ☐ **CHANGE** information ☐ **REMOVE** from list

Provider Name: ______________________________
MAT certificate expiration date: __________
Signature indicates verification of age, MAT certificate, first aid and CPR certificates: ____________________________ Date: _____________

The following individual(s) has a professional license or certificate which exempts him/her from the training requirements to administer medication. Copies of the individual(s) credentials are attached.

(Check one) ☐ **ADD** to list ☐ **CHANGE** information ☐ **REMOVE** from list

Name: ______________________________
License/certificate **(circle one)**: RN LPN PA NP MD DO Pharmacist
License/certificate expiration date: __________

Signature indicates verification of age and licensure:
_____ Date: _____

ONLY COMPLETE THIS SECTION IF THE PROGRAM **WILL** ADMINISTER MEDICATION

Section 7: Forms and Documentation Related to Medication Administration

Medication Consent Form: **(check all that apply)**

☐ My program will accept permission and instructions to administer medication on the VDSS form *Written Medication Consent Form.*

☐ My program will accept permission and instruction to administer medication on the attached medication consent form developed by my program. (Please attach)

☐ Other:
_____
_____

Medication consent forms for long-term medication must be renewed every six months. How will you review written medication consents and instruction to verify they are current and have not expired?
_____
_____
_____

All medication administered to a child during program hours will be documented on a child-specific medication log.

My program used the following form to document the administration of medication during program hours: **(check one)**

☐ VDSS form *Log of Medication Administration*

☐ The attached log of medication administration developed by the program (please attach)

My program uses the following form to document the application of over-the-counter topical ointments, sunscreen and topically applied insect repellent during program hours: **(check all that apply)**

☐ VDSS form *Log of Medication Administration*

☐ Log of medication administration developed by the program (please attach)

☐ Other:

Each medication log will be attached to the child's corresponding medication consent form.

ONLY COMPLETE THIS SECTION IF THE PROGRAM **WILL** ADMINISTER MEDICATION

All observable side effects will be documented on the child's medication log. Parents will be notified on any observed side effects by the end of the day. Parent notification will be immediate if the side effects are severe. If necessary, emergency medical services will be called.

Parents will be notified of all "as needed" medication given to their child and told what symptoms were observed that required the administration of medication.

I (or my staff) will document whenever medication is not given as scheduled. The date, time and reason for this will be documented. Parents will be notified as soon as possible. If the failure to give medication as scheduled is a medication error, I (or my staff) will follow all policies and procedures related to medication errors.

All medication consents and medication logs will be kept in the follow location (manner):

☐ Child's file

☐ Medication log book

☐ Other: _____

Section 8: Handling Storage and Disposal of Medication

All medication must be properly labeled with the child's first and last name and be accompanied by the necessary parent permission and, when applicable, health care provider instructions in accordance with VDSS regulations before it will be accepted from the parent or parent representative.

All medication will be kept in its original labeled container.

Medication must be kept in a locked place using a safe locking method that prevents access by children. Explain where medication will be stored. Note any medications, such as EpiPen®, which may be stored in a different area.

_____
_____
_____
_____

Medication requiring refrigeration will be stored: **(check one)**

☐ In a medication-only refrigerator located _____

☐ In a food refrigerator in a leak proof container separated from food and inaccessible to children

☐ Other: _____

ONLY COMPLETE THIS SECTION IF THE PROGRAM **WILL** ADMINISTER MEDICATION

Any refrigerator used to store medication will be kept at a temperature below 40ºF.

All medications with a pharmacy label identifying the contents as a controlled substance are regulated by the Federal Drug Enforcement Agency. These medications will be: **(check all that apply)**

- ☐ Stored in a locked area with limited access
- ☐ Counted when receiving a prescription bottle from a parent or guardian
- ☐ Counted each day if more than one person has access to the area where they are stored
- ☐ Counted before given back to the parent for disposal
- ☐ Other: _____

Explain where controlled substances will be stored and who will have access to these medications:

_____
_____
_____

I (or my staff) will check for expired medications: (check one)

- ☐ Weekly
- ☐ Monthly
- ☐ Other: _____

All leftover or expired medication will be given back to the child's parent for disposal. Medication not picked up by the parent within (specify timeframe) _____ will be flushed down the toilet or disposed of in a garbage container that is not accessible to children.

Section 9: Medication Errors

If a medication error occurs in my program, I will notify the child's parent immediately. I will maintain confidentiality of all children involved.

When any medication error occurs, I will do the following:

- I will encourage the child's parent to contact the child's health care provider when the error occurs.
- I will complete the VDSS form *Medication Error Report Form* to report all medication errors that occur in my program. If more than one child is involved in the error, I will complete a *Medication Error Report* Form for each child involved.

- In addition, I have decided that I will notify these people: If no additional notifications, put N/A in this section.

  _____
  _____

Section 10: Confidentiality Statement

Information about any child in my program is confidential and will not be given to anyone except VDSS designees or other person authorized by law unless the child's parent gives written permission.

Information about any child in my program will be given to the local department of social services if the child receives a day care subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

Section 11: ADA Statement for Programs

My program will comply with the provisions of the Americans with Disabilities Act. If any child enrolled in my program now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the program to meet the needs of the child. If my program can meet the needs of the child without making a fundamental alternation to the program, I will not exclude the child from my program.

Section 12: Provider Statement

I understand that it is my responsibility to follow my *PROGRAM'S DECISION REGARDING MEDICATION* plan and all health and infection control regulations applicable to child day programs.

I will verify and document the credentials for all new staff certified to administer medication before the staff is allowed to administer medication to any child in the child day program.

The *PROGRAM'S DECISION REGARDING MEDICATION* plan will be made available to parents at enrollment, whenever changes are made and upon request.

Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name (please print):	Facility Name:
Provider's Signature:	Date:
Parent or Guardian's Signature:	Date: