BETHEL DAYCARE MINISTRY

MEDICATION CONSENT FORM

02/2012

<table>
<tr><td colspan="5">First & Last NAME of CHILD:</td></tr>
<tr><td>Type/Name of Medication:</td><td colspan="2">Prescription #:</td><td>Dosage:</td><td>Route (method):</td></tr>
<tr><td>Non-prescription:

YES___ NO___</td><td>Start Date:</td><td>End Date:</td><td colspan="2">Times & Frequency:</td></tr>
<tr><td colspan="5">Reason:</td></tr>
<tr><td colspan="5">Possible Side Effects:</td></tr>
<tr><td colspan="5">Medication’s Expiration Date:</td></tr>
<tr><td colspan="5">Directions For Storage & Disposal:</td></tr>
<tr><td colspan="3">Child’s Healthcare Provider:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="3">Healthcare Provider’s Signature:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="3">Parent Signature:</td><td colspan="2">Date:</td></tr>
</table>

Physician's Order for sunscreen, acetaminophen, Epi-pen, triple antibiotic ointment, A & D ointment, etc. may be faxed to Bethel Daycare Ministry. (Fax # 489-6456) Physician's Order expires one year from original date.

MEDICATION CONSENT STAFF REVIEW:

Is the medication form complete? _____

Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer? _____

Is the child's full name on the container? _____

Is the prescription or over the counter medication current? _____

Is the dose, name of drug, frequency of administration given on label consistent with instructions above? _____

Is there a physicians order and is it current? _____ (may not exceed one year)

Document medication given on Medication Documentation Form.

***Please note that prescription medications in their original container with current prescription label is not required to have a physician's signature for this Medication Consent Form. Parent Guardian signature is required for each medication to be administered.**

MEDICATION DOCUMENTATION FORM

NAME OF CHILD:

DATE	NAME OF MEDICATION	RX #	DOSE	ROUTE	TIME	SIGNATURE OF STAFF ADMINISTERING MEDICATION

SIDE EFFECTS

ENCOUNTERED:_____DATE_____TIME_____STAFF_____

_____DATE_____TIME_____STAFF_____

_____DATE_____TIME_____STAFF_____

_____DATE_____TIME_____STAFF_____

_____DATE_____TIME_____STAFF_____

_____DATE_____TIME_____STAFF_____