

**Group Activity: Receiving Medication, Scenario 1**

Nick is 15-months-old and has an ear infection. Nick needs a noon time dose of amoxicillin suspension for this week and part of next week. The medication requires refrigeration and it must be shaken before being given. Nick has already received several doses of amoxicillin at home.

**Group Activity: Receiving Medication, Scenario 1****AJ's Pharmacy****444 Medicine Way  
Blue Sky, NC 27599****Keep your family healthy for less****Dr. E. Donoghue  
(732) 775-5500****PH (800)333-6868****NO 0123456-78907****DATE 09/20/2009****Nick Sample****123 Main Street  
Anywhere, USA****Take one teaspoon by mouth  
three times daily for 10 days****Shake before using.****Amoxicillin Suspension 250 mg/5 cc****MFG BIGCOMPANY****NO REFILLS - DR. AUTHORIZATION REQUIRED****USE BEFORE 06/2020**

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### Medication Administration Packet

Authorization to Give Medicine PAGE 1—TO BE COMPLETED BY PARENT		
<b>CHILD'S INFORMATION</b>		
ABC Child Care Center		X / X / 20xx
Name of Facility/School		Today's Date
Nick Sample		Y / Y / 0Y
Name of Child (First and Last)		Date of Birth
Name of Medicine Amoxicillin Suspension 250mg / 5cc		
Reason medicine is needed during school hours Ear Infection		
Dose One teaspoon		Route By mouth
Time to give medicine Noon		
Additional instructions		
Date to start medicine 0 / 0 / 20xx Monday		Stop date X / X / 20xx
Known side effects of medicine Diarrhea		
Plan of management of side effects Rice cereal and yogurt to eat		
Child allergies None		
<b>PRESCRIBER'S INFORMATION</b>		
Elaine Donoghue, MD		
Prescribing Health Professional's Name		
(732) 775-5500		
Phone Number		
<b>PERMISSION TO GIVE MEDICINE</b>		
I hereby give permission for the facility/school to administer medicine as prescribed above. <u>I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.</u>		
Nicole Sample		
Parent or Guardian Name (Print)		
[Signature]		
Parent or Guardian Signature		
123 Main Street, Anywhere USA		
Address		
123-4567	234-5678	987-6543
Home Phone Number	Work Phone Number	Cell Phone Number

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## UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) <b>Sample</b>		Child's Name (First) <b>Nick</b>		Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <b>Y 1 Y 1200Y</b>
Does Child Have Health Insurance? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier <b>BC/BS</b>			
Parent/Guardian Name <b>Nicole Sample</b>		Home Telephone Number <b>123-4567</b>		Work Telephone/Cell Phone Number <b>234-5678</b>	
Parent/Guardian Name <b>Michael Sample</b>		Home Telephone Number <b>123-4567</b>		Work Telephone/Cell Phone Number <b>987-6543</b>	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date <b>Nicole Sample</b>				This form may be released to WIC. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: <b>2/2/2002</b>		Results of physical examination normal? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted:  <b>Ø</b>		Weight (must be taken within 30 days for WIC)		<b>25 lbs</b>	
		Height (must be taken within 30 days for WIC)		<b>30 inches</b>	
		Head Circumference (if <2 Years)		<b>46 cm</b>	
		Blood Pressure (if ≥3 Years)			
<b>IMMUNIZATIONS</b>		<input checked="" type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: <b>At two years of age</b>			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments <b>Occasional ear infections</b>	
Limitations to Physical Activity • List limitations/special considerations:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input checked="" type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct	<b>2/2/2002</b>	<b>11/33</b>	Hearing	<b>Birth</b>	<b>Passed</b>
Lead: <input checked="" type="checkbox"/> Capillary <input type="checkbox"/> Venous	<b>2/2/2002</b>	<b>3</b>	Vision		
TB (mm of Induration)			Dental		
Other:			Developmental	<b>2/2/2002</b>	<b>Normal</b>
Other:			Scoliosis		
<input checked="" type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print) <b>Elaine Donoghue, MD</b>			Health Care Provider Stamp:		
Signature/Date <b>Elaine Donoghue</b> <b>XX/XX/XX</b>					

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### Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child Nick Sample  
Name of medicine Amoxicillin Suspension 250/5 cc  
Date medicine was received X / X / 20xx

#### Safety Check

- ☐ 1. Child-resistant container.
  - ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
  - ☐ 3. Name of child on container is correct (first and last names).
  - ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
  - ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
  - ☐ 6. Copy of Child Health Record is on file.
  - ☐ 7. Instructions are clear for dose, route, and time to give medicine.
  - ☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
  - ☐ 9. Child has had a previous trial dose.
- Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

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#### CHILD'S INFORMATION

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Nick Sample Y / Y / 20xx  
Name of Child (First and Last) Date of Birth  
Name of Medicine Amoxicillin Suspension 250 mg / 5cc  
Reason medicine is needed during school hours Ear infection  
Dose \_\_\_\_\_ Route By mouth  
Time to give medicine Noon  
Additional instructions \_\_\_\_\_  
Date to start medicine 0 / 0 / 20xx Monday Stop date X / X / 20xx  
Known side effects of medicine Diarrhea  
Plan of management of side effects Rice cereal and yogurt to eat  
Child allergies None

#### PRESCRIBER'S INFORMATION

Elaine Donoghue, MD  
Prescribing Health Professional's Name  
(732) 775-5500  
Phone Number

#### PERMISSION TO GIVE MEDICINE

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Nicole Sample  
Parent or Guardian Signature  
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Address  
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Home Phone Number Work Phone Number Cell Phone Number