

Exercise: Finding the *Five Rights*



Case Study 1: Over-the-Counter Medication

Directions: Circle each of the **Five Rights** on the medication package below. Write each Right on the line provided. Then, circle the **Five Rights** on the *Written Medication Consent Form* on the next page and match each one with the **Five Rights** on the medication package.



1. Right Medication: _____
2. Right Time: _____
3. Right Dose: _____
4. Right Route: _____
5. Right Child: _____



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OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
WRITTEN MEDICATION CONSENT FORM



- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

1. Child's first and last name: Missy Franklin	2. Date of birth: 4-3-XX (6 months old)	3. Child's known allergies: None known
4. Name of medication (including strength): Baby Orajel	5. Amount/dosage to be given: Small pea-size amount	6. Route of administration: apply to red or swollen gums
7A. Frequency to be administered: _____ OR		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) increased irritability, fussiness and/or red, swollen and painful gums; apply no more than 2 times a day while in care		
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects (parent must supply) AND/OR		
8B: Additional side effects: _____		
9. What action should the child care provider take if side effects are noted: <input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions (parent must supply) AND/OR		
10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____		
11. Reason the child is taking the medication (unless confidential by law): Discomfort due to teething		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #33-#34 on the back of this form.		
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #35-#36 on the back of this form.		
14. Date prescriber authorized: 9/29/XX	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):	
16. Prescriber's name (please print): Dr. Margaret Valens	17. Prescriber's telephone number: (718) 555-2345	
18. Licensed authorized prescriber's signature: X Margaret Valens, M.D.		

This is a double-sided form

Updated 11-04

Case Study 2: Prescription Medication

Directions: Circle each of the **Five Rights** on the prescription label below. Write each Right on the line provided. Then, circle the **Five Rights** on the *Written Medication Consent Form* on the next page and match each one with the **Five Rights** on the label.

Pharmacy Inc. #0012 Ph: 914-555-0102
100 Main Street, NYC, NY 10068
Rx#: 8145973-02 Tx: 8063264

Jose Martinez DOB: 11/30/XX
(914) 554-1984
461 Park Place, Brooklyn, NY 11202

albuterol (90mcg/inh)
(generic form of Ventolin®)


Give two puffs by oral inhaler as directed. May give every four hours up to three doses per day.

Prescriber: **Nancy Wallace MD (914) 564-9832**
221 Stream Place, Brooklyn, NY 11202
Refillable: 0 times QTY: 1 R.Ph. Init: RSL
Date filled: 7/15/XX Orig. Date: 7/15/XX Exp. Date: 7/15/XX

1. Right Medication: _____
2. Right Time: _____
3. Right Dose: _____
4. Right Route: _____
5. Right Child: _____



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OCFS-LDSS-7002 (11/2004)		NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES WRITTEN MEDICATION CONSENT FORM		
<ul style="list-style-type: none"> This form must be completed in a language in which the child care provider is literate. One form must be completed for each medication. Multiple medications cannot be listed on one consent form. 				
LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18) <i>(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)</i>				
1. Child's first and last name: <i>José Martinez</i>	2. Date of birth: <i>11-30-XX (6 years old)</i>	3. Child's known allergies: <i>Dust, pollen</i>		
4. Name of medication (including strength): <i>Albuterol 90 mcg/inh</i>	5. Amount/dosage to be given: <i>2 puffs</i>	6. Route of administration: <i>inhaled</i>		
7A. Frequency to be administered: _____				
OR				
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) <i>difficulty breathing, wheezing, and/or shortness of breath. May repeat dose in four hours, if needed.</i>				
8A. Possible side effects: <input checked="" type="checkbox"/> See package insert for complete list of possible side effects (parent must supply)				
AND/OR				
8B: Additional side effects: _____				
9. What action should the child care provider take if side effects are noted:				
<input checked="" type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____				
10A. Special instructions: <input checked="" type="checkbox"/> See package insert for complete list of special instructions (parent must supply)				
AND/OR				
10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____				
11. Reason the child is taking the medication (unless confidential by law): <i>Asthma</i>				
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #33-#34 on the back of this form.				
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #35-#36 on the back of this form.				
14. Date prescriber authorized: <i>7/15/XS</i>	15. Date to be discontinued or length of time in days to be given (<i>this date cannot exceed 6 months from the date authorized or this order will not be valid</i>):			
16. Prescriber's name (please print): <i>Dr. Nancy Wallace</i>	17. Prescriber's telephone number: <i>(718) 564-9832</i>			
18. Licensed authorized prescriber's signature: X <i>Nancy Wallace, M.D.</i>				

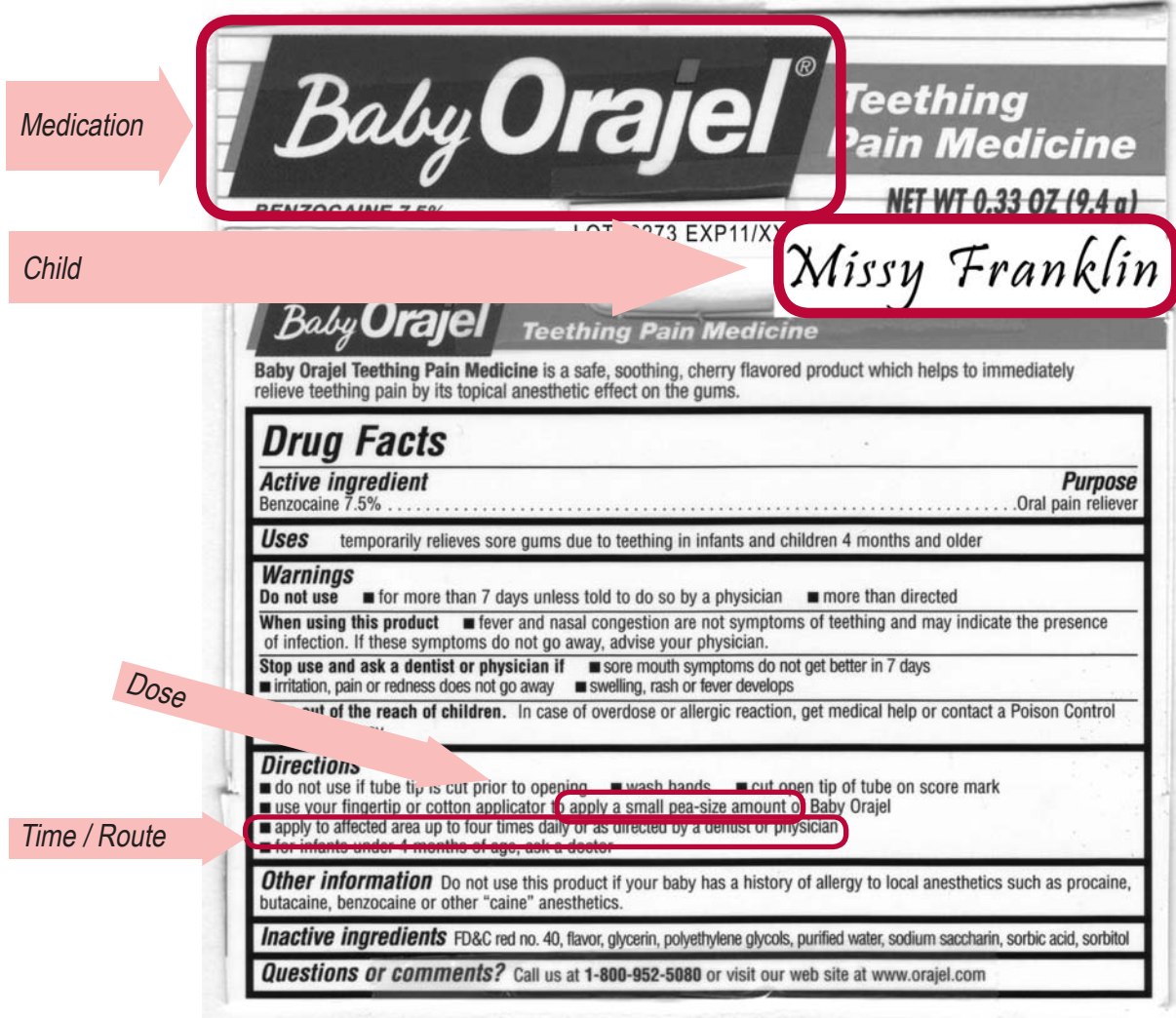
This is a double-sided form

Updated 11-04

Exercise: Finding the *Five Rights* ANSWER KEY



Case Study 1: Over-the-Counter Medication



Medication → **Baby Orajel** Teething Pain Medicine

Child → *Missy Franklin*

Dose → **Directions**

Time / Route → **Directions**

Drug Facts

Active ingredient	Purpose
Benzocaine 7.5%	Oral pain reliever

Uses temporarily relieves sore gums due to teething in infants and children 4 months and older

Warnings

Do not use ■ for more than 7 days unless told to do so by a physician ■ more than directed

When using this product ■ fever and nasal congestion are not symptoms of teething and may indicate the presence of infection. If these symptoms do not go away, advise your physician.

Stop use and ask a dentist or physician if ■ sore mouth symptoms do not get better in 7 days ■ irritation, pain or redness does not go away ■ swelling, rash or fever develops

Directions

- do not use if tube tip is cut prior to opening ■ wash hands ■ cut open tip of tube on score mark
- use your fingertip or cotton applicator to apply a small pea-size amount of Baby Orajel
- apply to affected area up to four times daily or as directed by a dentist or physician
- for infants under 4 months of age, ask a doctor

Other information Do not use this product if your baby has a history of allergy to local anesthetics such as procaine, butacaine, benzocaine or other "caine" anesthetics.

Inactive ingredients FD&C red no. 40, flavor, glycerin, polyethylene glycols, purified water, sodium saccharin, sorbic acid, sorbitol

Questions or comments? Call us at 1-800-952-5080 or visit our web site at www.oraljel.com

- Right Medication: Baby Orajel 7.5%
- Right Time: When Missy shows these symptoms: increased irritability, fussiness and/or red, swollen and painful gums due to teething. (Label states "as directed," so follow the health care provider instructions when matching the right time.)
- Right Dose: small pea-size amount
- Right Route: Apply to red or swollen gums. (Label states "as directed," so follow the health care provider instructions when matching the right route.)
- Right Child: Missy Franklin



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