Exercise: Finding the Five Rights

ANSWER KEY

Case Study 1: Over-the-Counter Medication

1. Right Child: ____________ Missy Franklin ____________
2. Right Medication: ____________ Orajel 7.5% ____________
3. Right Dose: ____________ small pea-size amount ____________
4. Right Route: ____________ Apply to red or swollen gums. (Label states “as directed,” so follow the health care provider instructions when matching the right route.)
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.)
# Medication Consent Form

**Child Day Care Programs**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**Licensed Authorized Prescriber Complete This Section (#1 - #18) and as Needed (#33 - 35)**

<table>
<thead>
<tr>
<th>Child's First and Last Name:</th>
<th>Missy Franklin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>4-3-XX (6 months old)</td>
</tr>
<tr>
<td>Child's Known Allergies:</td>
<td>None known</td>
</tr>
</tbody>
</table>

**4. Name of Medication (including strength):**

- **Orajel 7.5%**

**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:**

- 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:**

- Contact parent
- Contact health care provider at phone number provided below
- Other (describe):

**10A. Special instructions:**

- 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 situation’s when medication should not be administered.

**11. Reason for 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 requires health and related services of a type or amount beyond that required by children generally?**

- No
- Yes

**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?**

- No
- Yes

**14. Date Health Care Provider Authorized:**

- 9/29/XX

**15. Date to be Discontinued or Length of Time in Days to be Given:**

**16. Licensed Authorized Prescriber’s Name (please print):**

- Margaret Valens, M.D.

**17. Licensed Authorized Prescriber’s Telephone Number:**

- (718) 555-2345

**18. Licensed Authorized Prescriber’s Signature:**

- X  Margaret Valens, M.D.
**Answer Key 2.1**

**NEW YORK STATE**

**OFFICE OF CHILDREN AND FAMILY SERVICES**

**MEDICATION CONSENT FORM**

**CHILD DAY CARE PROGRAMS**

**PARENT COMPLETE THIS SECTION (#19 - #23)**

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)*

- [ ] Yes
- [x] N/A
- [ ] No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*:

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child’s name)*: Missy Franklin

- Parent’s Name (please print):
  - Andrea Franklin

- Date Authorized:
  - 9/29/XX

**CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)**

24. Program Name:
- ABC Child Care

25. Facility ID Number:
- 01376 DCC

26. Program Telephone Number:
- (212) 555-8363

27. I have verified that (#1 - #23) and if applicable, (#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

- Staff’s Name (please print):
  - Carla Carson

- Date Received from Parent:
  - 9/29/20XX

**ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)**

31. I, parent, request that the medication indicated on this consent form be discontinued on *(Date)*

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

- Parent Signature:
  - [X]

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

- DATE:

By completing this section, the day care program will follow the written instruction on this form and not follow the pharmacy label until the new prescription has been filled.

- Licensed Authorized Prescriber’s Signature:
  - [X]
Case Study 2: Prescription Medication

Medication: 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 Child: José Martinez
2. Right Medication: albuterol 90 mcg/inh
3. Right Dose: 2 puffs
4. Right Route: inhaled by oral inhaler
5. Right Time: When José shows these symptoms: shortness of breath, wheezing, complaint of difficulty breathing. (Label states “as directed,” so follow the health care provider instructions when matching the right time.)
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**NEW YORK STATE**
**OFFICE OF CHILDREN AND FAMILY SERVICES**

**MEDICATION CONSENT FORM**
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child’s First and Last Name: José Martinez
2. Date of Birth: 11-30-XX (6 years old)
3. Child’s Known Allergies: Dust, pollen
4. Name of Medication (including strength): Albuterol 90mcg/inh
5. Amount/Dosage to be Given: 2 puffs
6. Route of Administration: inhaled
7A. Frequency to be administered: ___________
7B. Identify the symptoms that will necessitate administration of medication: Difficulty breathing, wheezing, and/or shortness of breath. May repeat dose in four hours, if needed.
8A. Possible side effects:☐ 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: ☐ Contact parent ☐ Contact health care provider at phone number provided below ☐ Other (describe): ___________
10A. Special instructions: ☐ 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 situation’s when medication should not be administered.) ___________
11. Reason for medication (unless confidential by law): Asthma
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally? ☐ No ☐ Yes  If you checked yes, complete (#33 and #35) 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? ☐ No ☐ Yes  If you checked yes, complete (#34 -#35) on the back of this form.
14. Date Health Care Provider Authorized: 7/15/XX
15. Date to be Discontinued or Length of Time in Days to be Given: ___________
16. Licensed Authorized Prescriber’s Name (please print): Nancy Wallace, M.D.
17. Licensed Authorized Prescriber’s Telephone Number: (718) 564-9832
18. Licensed Authorized Prescriber’s Signature: X Nancy Wallace, MD
OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM
CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the licensed authorized prescriber write 12pm?)

☐ Yes  ☒ N/A  ☐ No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12 pm):

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to (child’s name):

José Martinez

21. Parent’s Name (please print):

Alicia Martinez

22. Date Authorized:

7/15/XX

23. Parent’s Signature:

X Alicia Martinez

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:

ABC Child Care

25. Facility ID Number:

01376 DCC

26. Program Telephone Number:

(212) 555-8363

27. I have verified that (#1 - #23) and if applicable, (#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff’s Name (please print):

Carla Carson

29. Date Received from Parent:

7/15/XX

30. Staff Signature:

X Carla Carson

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on ____________________________ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

See Individual Health Care Plan

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: ____________________________

By completing this section, the day care program will follow the written instruction on this form and not follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber’s Signature:

X Nancy Wallace, MD