

## Medication/Treatment/Action Plan

Authorization Form

**SECTION 1** In addition to the Medication Permissions and Instructions form (BCAL-1243), required by LARA, GTACS requires the following information for treating your student.

	<u> </u>								
Stu	dent Name		Grade	Teacher	Age				
	Diagnoses/Health Concern/Need								
ls t	Is this a LIFE THREATING condition? Yes No								
Wł	What triggers a reaction? (eating, touching, smelling)								
Sig	Signs or Symptoms your student is having a reaction or episode								
Emergency Action/Care Plan (What steps should staff take in case of emergency?) Step 1.									
Step 2.									
Step 3.									
Additional Steps									
Medical 504 Plan									
	ormation or a copy of this form will be given to yo				175 Line 1871				
as well as stored in the office with your child's medication. Upon request a Medial 504 Plan (developed with the same information given above.) can also be supplied to you and placed in your student's permanent									
	nool record (CA60 File).	ned to	you and pia	ced iii your student	s permanent				
	ould you like to be provided with a Medical 504 F	Plan fo	r your stude	nt? YES	NO				
SEC	CTION 2								
	A. All Medications/Supplies will be transported to and from school by parent/guardian/GTACS staff only. (Special accommodations made with written prescription from physician for medications like epi pens and inhalers.) All prescription medication will be in the original container, labeled by the pharmacy with physician name, student name, dosage, route and frequency and expiration date included on the label.								
	B. If the medication is changed or discontinued the parent must complete a "Change in Medication Sheet" supplied by GTACS.								
	C. In the event of a natural/human caused crisis/emergency, the teacher listed above and GTACS office staff will be responsible for following Emergency Action/Care Plans.								
By signing below, you are attesting to understanding and agreeing to the above statements.									
Par	ent/Guardian Signature		D	ate					
	Office Use Only 1st Staff Review Date Staff Initials:			Only 2 <sup>nd</sup> Staff Revis:					

## MEDICATION PERMISSION AND INSTRUCTIONS CHILD CARE HOMES AND CENTERS

Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY	PARENT				*				
I give my permission for									
		(Caregiver, F			1000				
(Specify, prescribe	(Specify, prescribed medication/over the counter product) , to my child, as follow (Child's Name)								
				(orma o r	turio)				
DIRECTIONS:  1. Date to Begin Giving Medication  2. Date to Stop Medication									
3. Times Medication is to be	Given		4. Amount (dosage) of Medication Each Time Given						
5. Storage of Medication									
6. Other Directions, if Any									
Signature of Parent Date									
TO BE COMPLETED E	BY THE CAREGIVER (	GIVING THE MEI	DICATIO	DN:					
DATE	TIME	AMOUNT GIVE		CAREGIVER'S NAME	CAREGIVER'S SIGNATURE				
-									
					у.				
	It is recommended this form	be reviewed with the	parent eve	ery 3 months if the medication is o	ngoing.				
LARA is an equal opportunity employer/program.									