



**AUMC Weekday Children's Programs**  
**Written Emergency Medication Consent Form**



**To be completed by child's Physician/Health Care Provider:**

1. Child's first and last name	2. Date of Birth	3. Child's known allergies
4. Name of medication (including strength)	5. Amount/dosage to be given	6. Route of Administration
7. Identify the symptoms that will necessitate administration of medication (Signs and symptoms must be observable and when possible, measurable parameters)		
8. Special instructions for administration (including when the medication should <b>not</b> be administered).		
9. What procedures should take place after administering this medication? <input type="radio"/> Call 911 <input type="radio"/> Call the parents <input type="radio"/> Call the Physician/Health Care Provider <input type="radio"/> Other _____		
10. Possible side effects (parents must provide pharmacy printout or package insert listing possible side effects)		
11. What action should the preschool take if side effects are noted: <input type="radio"/> Contact parent <input type="radio"/> Contact health provider at phone number provided _____ <input type="radio"/> Other _____		
12. 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 type="radio"/> No <input type="radio"/> Yes – If yes, complete below.		
13. Date	14. Date to be discontinued <i>(This authorization is valid for the entirety of the current school year)</i>	
15. Prescriber's name (please print)		16. Prescriber's telephone number
17. Licensed authorized prescriber's signature:		

**To be completed by Parent/Guardian:**

18. I, parent/legal guardian, authorize the AUMC Weekday Preschool & Early Learning Program to administer the medication as specified in the "Health Care Provider" section to _____ (child's name)	
19. Parent/legal guardian's name (please print)	20. Date authorized
21. Parent or legal guardian's signature:	

**To be completed by Director of WPS or ELP:**

22. Facility Name: <b>AUMC Weekday Preschool and Early Learning Program</b>	23. Telephone: <b>703-256-1100/703-256-8667</b>
24. I have verified the #1-20 are complete. My signature indicates that all information needed to give this medication has been given to the Weekday Preschool/Early Learning Program.	
25. Authorized person's name: <b>Cherrie S. Welch</b> Director	26. Date received from parent:
27. Director's signature:	

**Parental Request to Discontinue Medication Prior to the Date in #14:**

28. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ . 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.
29. Parent or legal guardian's signature: