First Discoveries Christian Preschool

Developing attitudes for success!℠

Incidental Medical Services - Agreed Plan of Operations Valid from __/__/___

Student: _____

Date of Birth: _____

Emergency Contact:_____

Emergency Phone: _____

FDCP is licensed and regulated by the California Department of Social Services, and is allowed to provide non-medical care and supervision to children 2-7 under California Law.

Incidental Medical Services Consent and Verification of Service Plan For Allergies

I, _____, give consent for the licensee, First Discoveries Christian Preschool, at 2177 Cottle Avenue, San Jose, CA 95125, to administer Incidental Medical Services and/or Medication to my child, _____, and to contact my child's health care provider *(named below)*.

_____ I certify that I have personally instructed the above-named licensee or staff persons on how to administer the medication to my child according to the attached physician's orders following all generally accepted safety precautions. I understand that at least one of the persons designated and trained to carry out the physician's medical orders will be onsite or present at all times when my child is in the care of FDCP.

_____ I certify that I have provided current, written medical instructions from my child's physician, which include the following:

[ ] Specific indications ***(symptoms)*** for administering the medication in accordance with the physician's prescription. Recap: _____

_____

[ ] Potential ***side effects*** and expected ***response***. Recap: _____

_____

[ ] Dose form and amount to be administered in accordance with the physician's prescription.

[ ] Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. Include actions to be taken in an emergency.

Recap: _____

Describe conditions when a call to 911 would be needed: _____

_____

[ ] Instructions for proper storage of the medication.

[ ] The telephone number and address of the child's physician .

Name: _____ Phone Number: _____

_____ I understand that my child's medication will be transported with him/her during any campus evacuation and/or field trip.

_____ I understand that it is my responsibility to communicate any new physician's orders (i.e. dosage changes, etc.), to track expiration dates and replace medicine and/or equipment/supplies as needed, and provide staff and student training *(by parent)* necessary for accommodations.

Medicines* to be kept at the school labeled *"as needed" listed on right:*

_____ LIC9221 & Medical Instructions or Action Plan on file? [ ] Yes, received __/__/__

_____ LIC9221 & Medical Instructions or Action Plan on file? [ ] Yes, received __/__/__

** Student shall not attend without these medications and their respective Consent/Instructions forms.*

Non-medical staff trained by parents or professional to administer medication/services: _____

_____

Allergy to _____

Allergy is: [ ] Severe (911) [ ] Moderate [ ] Mild

Medical Instructions/Action Plan on file? [ ] Yes [ ] No

Brief Action Plan for Allergic Reaction:

_____

_____

_____

_____

Medication to be kept on site:

_____

_____

- Medication on site already? [ ] Yes [ ] No

** Consent & Medical Instructions must be on site as well.*

- Does it expire before 12 months? [ ] Yes [ ] No

- Has staff been trained to administer it? [ ] Yes [ ] No

Dietary Accommodations Requested:

Avoid:_____

_____

_____

- Requesting meal replacements? [ ] Yes [ ] No

[ ] Meal Replacement Form received on __/__/___

- Require separate seating for breakfast? [ ] Yes [ ] No

Separate seating NOT available for lunch/snacks._____

INITIAL

Incidental Medical Services Agreement

Accommodation Plan Acceptable [ ] Yes [ ] No

Accommodation Permanent [ ] Yes [ ] No

Parent Signature_____ __/__/___

Parent Name _____

Director Signature_____ __/__/___

Terry Beckett, Educational Director - 408.625.3773