First Discoveries Christian Preschool

Developing attitudes for success!℠

Medical Instructions for Incidental Medical Services - Plan of Operation

Student: _____

Date of Birth: _____

Emergency Phone: _____

Allergies: _____

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.

Instructions for Medication Dispensing and/or Administration of Incidental Medical Services by Non-Medical Staff

The following questions must be completed and signed by the child's physician only:

Description of child's medical condition requiring medication *(ie. Allergy, Asthma, Diabetes, etc.)*:

_____

_____

_____

Symptoms that indicate the administration of medication(s) is necessary *(ie. wheezing, hives, swelling in face, etc.)* If no medication is indicated first, state that clearly, and when it's indicated:

_____

_____

_____

Indicate what will happen if the administered medication is successful *(ie. wheezing stops, hives disappear, swelling in face disappears, etc.)*:

_____

_____

_____

What is the recommended action if the treatment is not successful *(ie. additional medications, transport to hospital, etc.)*:

_____

_____

_____

List possible side effects from administration of medication and if treatment for an observed side effect is necessary:

_____

_____

_____

_____ I certify that non-medical staff trained by the parent/guardian, with the following instructions, can administer the medication*(s)* and/or incidental medical services mentioned above. The detailed instructions are as follows: _____

_____

_____

_____ *(continue on back)*

Child's Personal Information:

Full Name: _____

Parent's Name: _____

Parent's Cell Phone: _____

Physician's Name *(please print)*:

_____

Physician's Phone Number:

_____

Name of medication(s) to be administered or incidental service to be provided "as needed":

1_____

2_____

3_____

Dosage:

1_____

2_____

3_____

Method of administration *(i.e. by mouth, by injection, etc.)*:

1_____

2_____

3_____

Time schedule for administration of medication or incidental medical service to be provided:

_____

_____

_____

_____

_____

Doctor's Signature & Date:

_____

Parent's Signature & Date:

_____