First Discoveries Christian Preschool

Developing attitudes for success!℠

Incidental Medical Services - Agreed Plan of Operation Valid starting __/__/___

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

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. Signature required on the right.

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: _____

_____

Medical Service requested:

[ ] Asthma Medication (Inhaler)

[ ] Or Describe your accommodation request here:

_____

_____

_____

_____

_____

_____

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

Medication to be kept on site:

_____

_____

_____

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

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

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

Any allergies? If yes, to: _____

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

- Requesting meal replacements? [ ] Yes [ ] No

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

For Food Allergies you must also complete forms: FDCP_DAR4FA and FDCP_IMSPO4FA18 [ ] Attached

Incidental Medical Services Agreement

Accommodation Plan Acceptable [ ] Yes [ ] No

Is the Plan Permanent [ ] Yes [ ] No, until __/__/___

Parent Signature_____ __/__/___

Parent Name _____

Physician Signature_____ __/__/___

Director Signature_____ __/__/___

Terry Beckett, Educational Director - 408.625.3773