NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I,_____, give my consent for_____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child,_____, and to contact my child's health care provider.
(PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- 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. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

INHALER OR NEBULIZER
PHYSICIAN'S INSTRUCTIONS

To be completed by Physician

CHILD'S NAME _____ DATE:_____

MEDICATION _____

SPECIFIC INDICATIONS (SYMPTOMS) FOR ADMISTERING THE INHALED MEDICATION _____

EXPECTED RESPONSE _____

POTENTIAL SIDE EFFECTS _____

DOSE FORM AND AMOUNT TO BE ADMINISTERED _____

ACTION TO BE TAKEN IN THE EVENT OF SIDE EFFECTS OR INCOMPLETE TREATMENT OR IN THE EVENT OF AN EMERGENCY

_____

PROPER STORAGE OF MEDICATION _____

Physician's Name/Signature _____ Address_____ Phone #_____