



YMCA OF SAN DIEGO COUNTY
Child & Youth Development

**INHALED MEDICATION: PHYSICIAN'S CHECKLIST (LICENSED FACILITIES)
(CHILD'S EVALUATION FOR APPROPRIATENESS OF CARE)**

PART A – INFORMATION TO BE COMPLETED BY PHYSICIAN

Name of Child: _____ Birthdate: _____

Assessment of Stability of Child's Medical Condition

Is the child's medical condition stable enough for a layperson with instruction/ training to safely administer medication to and properly care for the child in a childcare setting? Yes No

Please explain: _____

Designation of Person to Provide Instruction on Inhaled Medication

If the answer to the above question is yes, each person who administers the medication to the child must be instructed on how to provide that care by a competent person designated by the child's physician. Please indicate the person you designate to provide this instruction with regard to the above-named child (may be the child's authorized representative).

Name _____ Phone Number: _____

Address _____

Title or Relationship to Child: _____

Please provide specific steps for layperson to administer this medication to the child. The instructions must be updated annually, or whenever the child's needs dictate, and must include:

- The name and use of the medication.
- The name and use of any equipment and supplies needed.
- The proper dosage/ amount.
- The proper storage and cleaning.
- The method of administration.
- The time schedules by which the medication is to be administered.
- A description of any potential side effects and the expected protocol.
- A description of how to identify and respond to an emergency related to this medication/ condition.
- How long the child may need to be under direct observation following administration of medication.
- Whether the child should rest and when the child may return to normal activities.

Physician: _____ Date of Last Physical Exam: _____ Current Date: _____

Address: _____ Telephone: _____

Signature: _____

PHYSICIAN PHYSICIAN'S ASSISTANT NURSE PRACTITIONER

PART B: INHALED TRAINING LOG

Name of Child: _____

Name of Designated Trainer: _____ Date of Training: _____

Name of all Staff Present during Training: _____

Signature of Trainer: _____ Date: _____

Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	

**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