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Medical Questionnaire & Medication Policy

Child's Name: _____

Parent/Guardian: _____ Phone: _____

Provider will only administer medication that is prescribed by a Doctor or medications required for allergic reactions. Provider must know which children (if any) use emergency medications, where the medications are stored, and how to administer them if necessary. Prescription medications must be in the original container with a prescription label on it. The prescription label must include: the name of the physician, the child's name (must be the person for whom the medication is to be administered), date the medication was prescribed and the instructions for dosage. If your child requires Prescription Medication to be administered at the Daycare, a Medication Administration Form will need to be filled out and signed by the Parent/Guardian (see Medication Administration Procedures below).

A Provider will administer Emergency Medications that are required for allergic reaction.

However, Parents/Guardians must inform their provider of possible allergies. This information is to be recorded in the child's medical questionnaire below. A letter from the child's physician with information pertaining to the allergy, symptoms of allergic reaction, medication required, dose to be administered, how often to administer medication, will be required for the child's file. A



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provider will not, under any circumstance, administer any other medication by mouth that is not prescribed by a physician. Parents/Guardians of the child are welcome to administer the medication themselves. However, they must inform the provider of the medication given and the time it was given (even if this was given at home before daycare). This is a precautionary measure in case the child has a delayed reaction throughout the day. If a child requires medication such as Tylenol to treat symptoms such as fever, severe cough, or pain it is recommended that Parents refer to their Policy and Procedure Manual before bringing the child to daycare. Children that have these symptoms should remain at home until they are symptom free.

If a child requires Topical Cream or ointment, the Parents/Guardians must inform the provider and a Medication Administration form will be required.

We are asking your assistance in identifying any medical condition that your child may have. Please complete all sections to best of your ability – or with your family doctor’s assistance. With this information a provider can provide the safest possible environment, the most appropriate response in the event of a medical emergency, and the development of a Health Care Plan, if necessary.

ANAPHYLAXIS Medical Code: X

1. Does your child have a physician diagnosed ‘LIFE THREATENING’ allergy? Yes _ No _

If “NO” to the above question, go to the next section.

2. Have you provided a written confirmation of allergy from you doctor. Yes _ No _

3. What triggers the reaction?



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4. Signs and symptoms of your child's reaction?

5. Does your child require an Epi-pen? Yes _ No _

6. Does your child carry an Epi-pen at all times? Yes _ No _

SEIZURES Medical Code: S

1. Does your child have a history of seizures? Yes _ No _

If "NO" to the above question, go to the next section.

2. Seizures began at _____ years of age.

3. Seizures last approximately _____ minutes.

4. Signs and symptoms of your child's seizure?

6. Seizure medication? _____ Yes _ No _

7. Child has been seizure free for _____ months/years.

DIABETES Medical Code: D

1. Does your child have diabetes? Yes _ No _

If "NO" to the above question, go to the next section.

2. Does your child have consistent control of blood glucose? Yes _ No _

3. What is the normal blood glucose range for your child? _ 4-7 _ 8-10 _ 10-13



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4. Does your child carry monitoring equipment daily? Yes _ No _

5. Describe your child's Hypoglycaemia (Low Blood Glucose) _____

7. My child attends Diabetic Clinic regularly Yes _ No _

8. The last A1C was _____ on (date) _____

ASTHMA Medical Code: A

1. Does your child have physician diagnosed asthma? Yes _ No _

If "NO" to the above question, go to the next section.

2. Degree of asthma? Mild Moderate Severe

3. Has your child ever had an asthma attack? Yes

What triggers the reaction?

4. Signs and symptoms of your child's asthma?

5. Asthma medication? _____ Yes _ No _

6. How often does your child use their rescue inhaler? _ Daily _ Weekly _ Seasonally _ Last Year

It is recommended that the inhaler be carried on person at all times.



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MEDICATION Medical Code: M

1. Does your child require prescription medication during daycare hours? Yes _ No _

2. Medication? _____

(An “Authorization for the Administration of Prescribed Medication” Form must be completed)

OTHER Medical Code: O

1. Does your child have any significant physician diagnosed conditions? Yes _ No _

i.e, blood disorders, severe migraines, syndromes, disorders

Condition? _____

****IN CASE OF AN EMERGENCY, WE WILL CALL AN AMBULANCE****Parents are responsible for ambulance cost

Parent/Guardian Signature _____ Date: _____