

**NAVY CHILD AND YOUTH PROGRAMS
MEDICAL AUTHORIZATION FORM**

REQUIRING DIRECTIVE OPNAVINST 1700.9

Dear Pediatric Health Provider,

_____ has been excluded from Navy Child Care on _____ for the following
(child's name)
health reason:

Unable to participate in normal activities _____

Requires more care than the staff can provide _____

Displays what could be a symptom of an illness that merits exclusion according to the American Academy of Pediatrics/American Public Health Association (available at <http://nrc.uchsc.edu/CFOC/index.html>) _____

Has a temperature _____
Degree Time

CYP Representative Signature: _____ Date: _____

Please assess this child by history and physical exam (labs only if needed) for:

- 1) the **presence of harmful communicable illness** such as, enteric pathogens (salmonella, shigella, E. coli 0157:H7, campylobacter, giardia, hepatitis A), pertussis, measles, mumps, varicella, rubella, diphtheria, or tuberculosis
- 2) the **presence of signs/symptoms of severe illness** such as, dehydration, respiratory distress, or lethargy
- 3) the **presence of any condition that would preclude the child from returning** to normal child care.

Please indicate below:

Harmful communicable disease No Yes

Signs of severe illness No Yes

Condition precluding return No Yes

If yes, may return once _____ resolves.

Diagnosis/Treatment

Please **complete the medication administration form** on the back (include Tylenol or Motrin!!) **Do not write prn orders.** These are confusing for child-care providers. **Include an Asthma Action Plan** for acutely ill asthmatics.

Signature/Stamp _____

**NAVY CHILD AND YOUTH PROGRAMS
MEDICATION ADMINISTRATION FORM**

REQUIRING DIRECTIVE OPNAVINST 1700.9

NAVY CYP MEDICATION ADMINISTRATION FORM

It is preferable that medication not be administered within the CYP Programs. When possible, parents and physicians should adjust medication schedules so that the program staff are not responsible for administration. We recognize that this is not always possible and we will agree to administer any medication as follows:

- v Written orders by a physician must be on file in order to administer any medication.
- v Parent/legal guardian must sign the liability release.
- v Child shall be monitored on the medication for 24 hours each time medication is prescribed before the program staff administers medication.
- v Children who need medications administered for extended time periods, or that have special health concerns will be required to complete Special Needs paperwork and be reviewed by the special needs review board.

ALL INFORMATION IN THIS SECTION MUST BE COMPLETED LEGIBLY BY A PHYSICIAN

Name of Child

Name of Medication to be Administered by CYP Staff

Time of Day and/or Frequency Medication is to be Administered

Duration of Medication (Dates)

Any Known Allergies

Can this medication schedule be adjusted so the medication is administered outside the CYP hours only? YES NO

Physician Signature

Date of Order

PARENTAL CONSENT/WAIVER/RELEASE AND INDEMNIFICATION

I hereby give consent for the CYP staff to administer medication to my child as directed above by the physician. I agree to indemnify and hold harmless Navy Child and Youth Programs, MWR, a non-appropriated fund instrumentality of the United States Navy, and any other instrumentality of the United States, and their officers, agents, and employees from any losses, expense, damage, claim, suit, or judgment arising out of or resulting from administration of medication to my child. As the parent/legal guardian, I agree to assume all risk associated with administration of medication including inadequacy or failure of staff and I also assure the said medication is safe for my child.

(Print) Parent Name

Signature

Date