RurAL CAP Head Start

Individual Administration of Medication Plan (IAMP)

Child's Name: ____________________________ Birth Date: ________________ Site: ___________________

Site staff will **only** administer prescription medication to Head Start children in the classroom after every effort has been made by the Parents, Staff and Physician to make the medication delivery schedule outside of Head Start operating hours and all medication procedures are completed and approved by the Regional Manager and Health/ Nutrition Coordinator.

Parent/ Guardian Statement:

I hereby request that prescribed medication to be given to my child: ____________________________________.

- I understand that the school is not legally obligated to administer medication to my child.
- I hereby give my consent for Head Start staff to administer the prescribed medication to my child.
- I will not hold RurAL CAP Head Start staff liable for any and all side effects that may result from administering this medication.
- I will notify Head Start immediately if my child's health status changes or there is a change or cancellation of the medication.
- I will provide the prescription medication in its original container, with the prescription label including the child's name, name of medication, dosage, dosage intervals, name of physician, date the prescription was filled and date the medication is to be discontinued.

Prescribed Medication Name:_____________________________ Prescribed Dose _______________

Home Phone/ VHF: _____________________________ Work Phone: _____________________

Emergency Contact Name, other than parent: _________________________ Phone #: ______________________

Name any other medication your child is taking: ____

Signature of Parent/Guardian: _________________________________Date: ___________________

Physician's Statement:

This medication must be given to: _______________________________ during school hours in order to maintain sufficient health and participation in the Head Start program and must receive prescribed medication during school hours for the following condition(s):____

Prescribed Medication Name:_____________________________ Prescribed Dose _______________

Time and dosage to be given in school: _______________________

Special dosage/ storage instructions: __________________________

Beginning Date: ________________________ Ending Date: __________________________

Possible side effects & symptoms: ____

Physician Signature: ________________________________ Date: _____________________

Print Name: _____________________________Phone:_________________________

Physician Address:____

Head Start Staff Statement:

Effect on classroom/ staffing pattern: ____

Employee **and** Alternate Employee have been designated and trained to administer this medication: ☐ Yes ☐ No

Employee Trained/ Date: __________________________ Alternate Trained/ Date: ________________________

Name of Trainer: ______________________________ Method of training:_______________________________

Medication properly labeled: ☐ Yes ☐ No

Plan for Storage: ____

Site Supervisor Signature ____Date: ___________________

IAMP form completed and signed with all required information: ☐ Yes ☐ No

Regional Manager Signature ___________________________________Date: _____________ ☐ Approved ☐ Denied

Family Services/ Health Coordinator Signature _________________________Date: _________ ☐ Approved ☐ Denied