Individual Administration of Medication Plan (IAMP)

RurAL CAP Head Start

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 Lead.

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 Statement:

This medication must be given to: _____ during school hours to maintain sufficient health and participation in the Head Start program. Child 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: _____

Physician 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

Health Lead Signature: _____ Date: _____ ☐ Approved ☐ Denied